ORIGINAL

Select Specialty Hospital-Memphis

CN1212-062

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND-NOT A WHITE BACKGROUND

Select Specialty Hospital - Memphis, Inc.
A Subsidiary of Select Medical Corp
4714 Gettysburg Road
Mechanicsburg, PA 17055

PNC Bank, National Association
JEANNETTE, PA

60-162/433

No. 33312110

Date: 12-DEC-12

Pay Fifteen Thousand Four Hundred Eighty-Seven Dollars And 00 Cents***

$ *****15,487.00

To The Order Of
STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT
500 DEADERICK STREET
SUITE 850
NASHVILLE, TN 37243

BY _____

BY _____

Signature Required if Amount Over $20,000.00

THIS DOCUMENT HAS A TRUE WATERMARK-HOLD TO LIGHT TO VIEW

⑈33312110⑈ ⑆043016277⑆ 10115650528

STATE OF TENNESSEE
Health Services and Dev Agency
Office 31607001
12/14/2012 3:38 PM

Cashier: annir0811001
Batch #: 431326
Trans #: 3
Workstation: AF0719WP45
==========
Receipt #: 08889583
HA01 CON Filing Fees $15,487.00
Payment Total: $15,487.00
==========
Transaction Total: $15,487.00

Check $15,487.00

Thank you for your payment.
Have a nice day!

CN12-003

DSG Development Support Group

2012 DEC 14 PM 3 44

December 14, 2012

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

RE: CON Application Submittal
Select Specialty Hospital--Memphis / Addition of 28 LTACH Beds
Memphis, Shelby County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Byron Trauger is legal counsel. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

AFFIDAVIT

2012 DEC 14 PM 3 44

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 14 day of December (Month), 2012 (Year) a Notary

Public in and for the County/State of Davidson / Tennessee.

NOTARY PUBLIC

My commission expires August 6 (Month/Day), 2016 (Year).

BEVIN M. SHELLENBERGER
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY

My Commission Expires August 6, 2016

SELECT SPECIALTY HOSPITAL MEMPHIS

CERTIFICATE OF NEED APPLICATION TO ADD 28 LONG TERM ACUTE CARE BEDS

Submitted December 2012

1. ***Name of Facility, Agency, or Institution***

Select Specialty Hospital--Memphis
Name

5959 Park Avenue
Street or Route

Shelby
County

Memphis
City

TN
State

38119
Zip Code

2. ***Contact Person Available for Responses to Questions***

John Wellborn
Name

Title

Development Support Group
Company Name

jwdsg@comcast.net
Email address

4219 Hillsboro Road, Suite 203
Street or Route

Nashville
City

TN
State

37215
Zip Code

CON Consultant
Association with Owner

615-665-2022
Phone Number

615-665-2042
Fax Number

3. ***Owner of the Facility, Agency or Institution***

Select Specialty Hospital--Memphis, Inc.
Name

901-761-3013
Phone Number

5959 Park Avenue
Street or Route

Shelby
County

Memphis
City

TN
State

38119
Zip Code

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G.	
C. Limited Partnership		H. Joint Venture	
D. Corporation (For Profit)	✔	I. Limited Liability Company	
E. Corporation (Not-for-Profit)		Other (Specify)_____	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity (If Applicable)***

NA
Name

Street or Route | County

City | State | Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A. Ownership	☐	D. Option to Lease	☐
B. Option to Purchase	☐	E. Other (Specify) _____	☐
C. Lease of 5 Years	✔		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A. Hospital (Specify)_____	✔	I. Nursing Home	☐
B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	☐	J. Outpatient Diagnostic Center	☐
C. ASTC, Single Specialty	☐	K. Recuperation Center	☐
D. Home Health Agency	☐	L. Rehabilitation Facility	☐
E. Hospice	☐	M. Residential Hospice	☐
F. Mental Health Hospital	☐	N. Non-Residential Methadone Facility	☐
G. Mental Health Residential Treatment Facility	☐	O. Birthing Center	☐
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)	☐	P. Other Outpatient Facility (Specify)_____	☐
		Q. Other (Specify) .	☐

8. **Purpose of Review *(Check) as appropriate--more than one response may apply)***

A. New Institution	☐	G. Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*	✔
B. Replacement/Existing Facility	☐		
C. Modification/Existing Facility	✔		
D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)_____	☐	H. Change of Location	☐
		I. Other (Specify)_____	☐
E. Discontinuance of OB Services	☐	.	.
F. Acquisition of Equipment	☐		

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital	39	10	39	28	77
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	39	10	39	28	77

*CON-Beds approved but not yet in service

10. Medicare Provider Number 44-2014

Certification Type long term care hospital

11. Medicaid Provider Number 044-2014

Certification Type long term care hospital

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid? p. 4

13. *Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.* Will this project involve the treatment of TennCare participants? p. 4 **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

This is an existing facility, already certified for Medicare and Medicaid. No change in certification is anticipated.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

Approximately 75%-80% of an LTACH's admissions tend to be elderly, and include patients who are also Medicaid-eligible. Select Specialty Hospital-Memphis is currently contracted with the BlueCare TennCare MCO--which has West Tennessee's largest enrollment. TennCare and Medicaid patients from Mississippi and Arkansas are accepted on an individually negotiated basis and Select is discussing a contract with Mississippi TennCare. Select's Medicaid days of care average between 3% and 4% of its total days of care.

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
BlueCare (largest plan in W. TN)	Contracted
United Healthcare Community Plan (formerly AmeriChoice) (2nd largest plan)	Not contracted; admissions available on a negotiated basis
TennCareSelect (very small enrollment)	Not contracted. Requested contract but was declined
Medicaid Programs- Arkansas, Mississippi	Admissions on negotiated basis

SECTION B: PROJECT DESCRIPTION

B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

Proposed Services and Equipment

• The applicant is a Long Term Acute Care Hospital ("LTACH"). That is a special category of small Medicare-certified hospitals. They admit primarily (but not only) vulnerable Medicare patients who need prolonged inpatient acute care (25+ days), after discharge from a short acute care stay at a general hospital.

• The 39-bed Select Specialty Hospital is the largest LTACH in Memphis. All 39 of its beds are in leased space on the 12th floor of St. Francis Hospital in East Memphis. Recently, Select Specialty received approval to add 10 beds (under an exemption from CON). St. Francis has agreed to lease its vacant 38-bed 11th floor to Select, for that expansion. Ten more beds can now be licensed to Select immediately. However, the entire floor needs updating through renovation and remodeling. This application is to license the remaining 28 beds on that 11th floor, which if approved will allow Select to renovate the entire 38-bed floor before moving many new patients onto the floor.

• St. Francis has agreed to delicense on this floor the same number of short term hospital beds that Select will re-license as long term acute care. So the project will not increase the area's total of long term plus short term hospital beds, or construct new bed space.

Ownership Structure

• Select Specialty Hospital--Memphis, Inc., the applicant, is wholly owned by Select Medical Corporation, a national LTACH company with five Tennessee facilities. Attachment A.4 contains information on the five Tennessee facilities it owns in Memphis, Nashville, Knoxville (2), and Tri-Cities.

• The facility is self-managed. It has no management contract with its parent company. The parent company provides certain support services to its hospitals, for which the hospitals are billed as "management fees", but at Select that is a practical business term and does not indicate a legal relationship other than normal parent-subsidiary ownership.

Service Area

• LTACH's typically have extensive service areas because they are located in cities with tertiary care centers that admit patients from a wide geographic service area, and then discharge some of those patients to LTACH's to continue prolonged acute care.

• During the past three years, Select Specialty Hospital has had a primary service area (85% of admissions) consisting of 17 contiguous counties in West Tennessee, Mississippi, and Arkansas (all closer to Memphis than to other cities with LTACH's). It

has had a primary and secondary service area (96.7% of admissions) consisting of 43 contiguous counties in those States (all but a few of which are closer to Memphis than to alternative LTACH's). It admitted patients from 78 counties in eight States.

Need

• There are only three LTACH's in the entire primary and secondary service area, and all of them are in Memphis. In the most recent reporting year, their Joint Annual Reports showed an average occupancy of 86.3%. Select is the largest and busiest of the Memphis LTACH's, and its occupancy over the past forty-eight months has averaged higher 93%. The smallest and least occupied is at 75.5% occupancy and will be at 85% occupancy with an additional census of only 28 patients.

• At such high occupancies, additional LTACH beds are appropriate. Although the LTACH bed need formula in the Guidelines for Growth does not indicate "need" for more beds, the same Guidelines allow the HSDA to consider bed additions once areawide LTACH occupancy reaches 85%--which has been exceeded in Memphis for at least three years.

• It is also relevant that the CON statute allows small hospitals (<100 beds) to add 10 beds every year without CON approval. Without CON, the 38 total beds Select can lease on this floor could be added in stages each year, until all 38 are licensed in early CY2016—only three years from now. But staging bed licensure will require staged renovation around patients being hospitalized on that floor. The alternative requested in this application is to let Select lease and license the remaining 28 beds from St. Francis without delay, making it feasible to invest in renovating the entire floor at the same time.

Existing Resources

• The LTACH's in the service area last reported a combined average occupancy of 86.3%. They are Select Specialty Hospital-Memphis (39 beds; 94.6% occupancy); Methodist Extended Care Hospital (36 beds; 86.3% occupancy); and Baptist Memorial Restorative Care Hospital (30 beds; 75.5% occupancy).

Project Cost, Funding, Financial Feasibility

• The actual capital cost of the project is estimated at $3,646,842. The CON cost, which includes the estimated value of the space being leased from St. Francis, is $6,898,842. The capital cost can be provided from the hospital's current assets. It could also be provided by a cash transfer from the parent company. Select Specialty Hospital--Memphis now operates with a positive margin and will continue to do so as it expands. The project is a small expenditure for an acute care facility and it will not raise the cost of care to Medicare or other payors. St. Francis Hospital itself would have to spend a similar amount of money to update and use the floor in the future, if Select were not leasing it.

Staffing

• The hospital projects that by Year Two of the expanded 77-bed complement, 55.8 additional employees will be required.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.)* INCLUDING SQUARE FOOTAGE, MAJOR OPERATIONAL AREAS, ROOM CONFIGURATION, ETC.

Table Two: Summary of Construction and Changes in Size	
	Total Square Feet
Facility Before Project	21,677 SF (12th floor of host hospital)
Facility After Project	43,354 SF (11th & 12th floors of host)
Area of New Construction	none
Area of Buildout or Renovation	21,677

Table Three: Construction Costs of This Project			
	Renovated Constuction	**New Construction**	**Total Project**
Square Feet	21,677 SF	none	21,677 SF
Construction Cost	$2,059,315	none	$2,059,315
Constr. Cost PSF	$95	none	$95

Select Specialty Hospital--Memphis ("Select Specialty") is licensed to operate a 39-bed long term acute care hospital ("LTACH") in Memphis. It is located at St. Francis Hospital, from whom Select Specialty leases the entire 39-bed 12th floor. Among Memphis's three operational LTACH's, Select Specialty is by far the most highly utilized, both in terms of annual patients served, and also in terms of occupancy (93% average over the past 48 months).

In December 2012, having higher than 90% occupancy during the past four-year period, Select Specialty requested and received HSDA approval to add 10 beds to its licensed complement without CON review, under a statutory exemption available to hospitals of fewer than 100 beds. However, no more beds are available on the 12th floor. So St. Francis has agreed to expand Select Specialty's leased space to include the

hospital's vacant 11th floor immediately below. The 11th floor is an acute care nursing unit consisting of 38 private rooms. It is older space that has not been updated for many years. It will require remodeling and renovation, but its floor plan need not be changed significantly. Because future bed expansions are anticipated, Select Specialty hopes to update the entire 38-bed 11th floor at one time, prior to occupying even the 10 recently approved beds, so that construction will not be required on an operational patient floor.

Select Specialty estimates that the 11th floor can be brought up to standards at an overall renovation cost of no more than $95 PSF, which will update the wall, floor, and ceiling surfaces, cabinetry, and fixtures, and allow for plumbing, HVAC, and electrical work. It will also cover heavier renovation if that is found to be needed. Tables One and Two below show the current and proposed floor space of the facility, and the projected cost of the renovation required to modernize it into LTACH space meeting Select Specialty's standards.

(Note: CMS is the Federal Center for Medicare/Medicaid Services; replacement for HCFA) In 2008, CMS placed a moratorium on Medicare certification of additional LTACH beds nationwide. This was extended once and is now scheduled to expire December 31, 2012. The Medicare moratorium may or may not be extended; but the applicant sees that as irrelevant to a CON decision on this application, because its future is unpredictable, and because Tennessee can license the beds it chooses regardless of when they might obtain Medicare certification. Providers should be ready to occupy needed beds as soon as the moratorium is lifted, and not have to wait four more months after the moratorium's expiration, to complete a CON process. As in other LTACH CON approvals since 2008, this efficiency can be accomplished simply by making operation of approved beds conditional on subsequent CMS certification.

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART.

UTILIZING THE ATTACHED CHART, APPLICANTS WITH HOSPITAL PROJECTS SHOULD COMPLETE PARTS A-E BY IDENTIFYING, AS APPLICABLE, NURSING UNITS, ANCILLARY AREAS, AND SUPPORT AREAS AFFECTED BY THIS PROJECT. PROVIDE THE LOCATION OF THE

UNIT/SERVICE WITHIN THE EXISTING FACILITY ALONG WITH CURRENT SQUARE FOOTAGE, WHERE, IF ANY, THE UNIT/SERVICE WILL RELOCATE TEMPORARILY DURING CONSTRUCTION AND RENOVATION, AND THEN THE LOCATION OF THE UNIT/SERVICE WITH PROPOSED SQUARE FOOTAGE. THE TOTAL COST PER SQUARE FOOT SHOULD PROVIDE A BREAKOUT BETWEEN NEW CONSTRUCTION AND RENOVATION COST PER SQUARE FOOT. OTHER FACILITY PROJECTS NEED ONLY COMPLETE PARTS B-E.

See Attachment B.II.A.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

This project is more economical than most. By comparison, the estimated $2,059,315 remodeling/renovation cost for the project is projected to be only $95 PSF. The 2009-2011 acute care construction projects approved by the HSDA had the costs per SF shown in Table Three below. This project's $95 PSF cost is below even 1st quartile averages for renovation ($125 PSF).

Table Four: Hospital Construction Cost PSF
Years: 2009 – 2011

	Renovated Construction	New Construction	Total Construction
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$125.84/sq ft	$324.00/sq ft	$301.74/sq ft

Source: CON approved applications for years 2009 through 2011

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

At the time of this application in December 2012, Select Specialty Hospital holds a 39-bed license for long term acute care hospital beds, and also holds HSDA approval to add 10 more of the same--which will give Select Specialty a 49-bed LTACH license when implemented in CY2013. The 10 new beds will be licensed to Select pursuant to a lease of 10 more private rooms from St. Francis Hospital--beds that are currently general, short term (not long term) acute care beds on the 11th floor. St. Francis will drop those 10 beds from its general acute care license, at the time Select takes control of the space and relicenses them as Select's own long term acute care beds. That is expected to happen in CY2013. Its timing will depend on this CON decision. Select hopes to be able to renovate the entire floor prior to using it for numerous new patients.

The same type of re-licensure process is proposed in this application. Select Specialty is requesting CON approval to license the remaining 28 long term acute care beds on the 11th floor, which would increase its LTACH license to 77 beds--39 on the 12th floor and 38 on the 11th floor. Again, this would be accomplished by conversion of short term general acute care beds now licensed to St. Francis. Table Five below presents these changes visually. All Select beds are, and will be, private patient rooms. There are no double rooms in this facility or this project.

Table Five: Proposed Changes in Licensed Hospital Beds
Select Specialty Hospital and St. Francis Hospital
Memphis

Provider / Bed Licensure	Approved Bed Assignment	Proposed Bed Assignment
Select Specialty Hospital / Long Term Acute Care	39 + 10 u.c. = 49	49 + 28 = 77
Ft. Francis Hospital / General Acute Care	519 - 10 u.c. = 509	509 - 28 = 481
Select and St. Francis Hospitals Combined	acute care beds, general & long term = 558	acute care beds, general & long term = 558

Note: "u.c." or "under construction", means here that Select Specialty is preparing to add 10 approved long term acute care beds in 11th-floor patient rooms it will lease from St. Francis (which St. Francis will then remove from the St. Francis acute care license).

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION):

1. **ADULT PSYCHIATRIC SERVICES**
2. **ALCOHOL AND DRUG TREATMENT ADOLESCENTS >28 DAYS**
3. **BIRTHING CENTER**
4. **BURN UNITS**
5. **CARDIAC CATHETERIZATION SERVICES**
6. **CHILD AND ADOLESCENT PSYCHIATRIC SERVICES**
7. **EXTRACORPOREAL LITHOTRIPSY**
8. **HOME HEALTH SERVICES**
9. **HOSPICE SERVICES**
10. **RESIDENTIAL HOSPICE**
11. **ICF/MR SERVICES**
12. **LONG TERM CARE SERVICES**
13. **MAGNETIC RESONANCE IMAGING (MRI)**
14. **MENTAL HEALTH RESIDENTIAL TREATMENT**
15. **NEONATAL INTENSIVE CARE UNIT**
16. **NON-RESIDENTIAL METHADONE TREATMENT CENTERS**
17. **OPEN HEART SURGERY**
18. **POSITIVE EMISSION TOMOGRAPHY**
19. **RADIATION THERAPY/LINEAR ACCELERATOR**
20. **REHABILITATION SERVICES**
21. **SWING BEDS**

This is a small but necessary project. It will serve patients needing prolonged acute care hospital stays of more than three weeks, following their discharge from short term acute care hospitals. It will improve resources within a 43-county region around Memphis, meeting elderly, vulnerable patients' needs in the most cost-effective and optimal way currently available.

The applicant, Select Specialty Hospital, is a 39-bed Long Term Acute Care Hospital ("LTACH" in this application). A preceding section of this application describes its East Memphis location on the 12th floor of St. Francis Hospital, a mile south of the Interstate 240 loop around Memphis. Select is the largest LTACH in Memphis and in 43 counties of the three States it serves.

There are only three LTACH facilities in the entire primary and secondary service area, and all of them are in Memphis. In the most recent reporting year, their Joint Annual Reports showed an average occupancy of 86.3%.

Select is the largest and busiest of the Memphis LTACH's, with higher than 93% average occupancy over the past forty-eight months. Methodist Extended Care Hospital (36 beds; 86.3% occupancy in CY2011); and Baptist Memorial Restorative Care Hospital (30 beds; 75.5% occupancy in CY2011) are the other two LTACH's in the service area. It is worth noting that even the smallest of these facilities is at 75.5% occupancy, and will be at 85% occupancy with an additional census of only 2.8 patients.

In December 2012, having averaged higher than 90% occupancy over the past four-year period, Select Specialty requested and received HSDA approval to add 10 beds to its licensed complement without CON review, under a statutory exemption available to hospitals of fewer than 100 beds. Select and its host hospital, St. Francis, are now finalizing a lease to allow that to proceed by a conversion of beds from St. Francis' licensure to Select's licensure.

Because the CON statute allows small hospitals (<100 beds) to add 10 beds every year without CON approval, it was Select Specialty's original intention to add 10 beds on that floor in stages, through early 2016, reaching the floor's full 38-bed capacity, and bringing Select's total license to 77 LTACH beds.

But it has become apparent that the entire floor needs remodeling and updating of all its patient care spaces; and it would obviously be better for patient care if that work could be completed in a single project, before more than 10 patients are brought onto that floor. This application seeks HSDA approval for going ahead in CY2013 with leasing, licensing, and remodeling all 38 bed spaces on that floor, eliminating the need for phased construction over the next 36 months in active patient care areas. If this approval is granted, it will be financially feasible for Select to invest in taking control of the whole floor without a staged-construction project to manage for thirty-six months.

Need for the beds at Select is overwhelming. Select's occupancy consistently exceeds 90%; in both CY2011 and CY2012, Select occupancy has been approximately 93%. The hospital continuously defers or turns away admissions for lack of bed space. This has gone on for years. It seems appropriate not to delay any longer in meeting community requests for this type of care, at this location.

LTACH Bed Need Guidelines

As addressed in this application's section on the Guidelines for Growth, the very old LTACH bed need formula in the Guidelines for Growth does not indicate "need" for more LTACH beds in this service area. But neither does it indicate a significant surplus of LTACH beds. And significantly, the same Guidelines state that the HSDA may approve bed additions once areawide LTACH occupancy reaches 85%--and that has been exceeded in Memphis for at least three years. The applicant urges the HSDA Board to thoughtfully weigh this real-world high rate of demand, and the well-documented aging of many service area counties, against the abstract "need" formula in the Guidelines.

Impact on Other LTACH's

This project will not impact the MED's newly approved 24-bed LTACH (a relocation). Nor will the MED's opening of those beds reduce other LTACH's high occupancies. MED representatives demonstrated in their CON application process that the MED has more qualified LTACH patients on extended acute stays in the MED than the 24 new beds can hold. So it appears that the MED beds will be fully occupied by MED patients who are not now asking for admission to Select or to other LTACH's in Memphis.

The Baptist and Methodist LTACH facilities are not likely to be harmed by the addition of beds at Select. They have high utilization that is not going to switch to Select in any significant way; Select anticipates filling its new beds through new marketing efforts at rural hospitals that are not discharging all their qualified patients to Memphis LTACH's at this time. Moreover, the Select bed addition will occur in stages by CY2016, if not allowed to open in CY2014 pursuant to a CON; so denial of this application would not provide competitive benefits of any duration to any other area LTACH.

B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

Not applicable.

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF $1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

1. For fixed site major medical equipment (not replacing existing equipment):

- **a. Describe the new equipment, including:**
  1. **Total Cost (As defined by Agency Rule);**
  2. **Expected Useful Life;**
  3. **List of clinical applications to be provided; and**
  4. **Documentation of FDA approval.**
- **b. Provide current and proposed schedule of operations.**

2. For mobile major medical equipment:

- **a. List all sites that will be served;**
- **b. Provide current and/or proposed schedule of operations;**
- **c. Provide the lease or contract cost;**
- **d. Provide the fair market value of the equipment; and**
- **e. List the owner for the equipment.**

3. Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not applicable. The project contains no major medical equipment.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:

1. **SIZE OF SITE (IN ACRES);**
2. **LOCATION OF STRUCTURE ON THE SITE;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

Select Specialty Hospital is on the twelfth floor of its host hospital, St. Francis Hospital. Select's address is 5959 Park Avenue, Memphis, Tennessee 38119. This is in East Memphis, approximately one mile south of the Poplar Avenue exit from Interstate 240 Loop circling that side of Memphis. The campus is well known to residents of Shelby County. It is served by a municipal bus line. However, almost all patients use private transportation to come to Select Specialty Hospital, because they are acute care patients for whom public transportation is not appropriate if alternatives are available. The applicant has no way of knowing what means of transport is used by visiting families.

This facility has a regional service area, as one would expect of LTACH's in cities with large tertiary healthcare systems. It has forty-three counties in its full (primary and secondary) service area. Table Six on the following page provides distances and drive times between Select Specialty and the largest community (or county seat) in the 17 Tennessee primary service area counties (those providing 85% of Select Specialty's admissions). Memphis is the hub of a complex network of interstate and Federal highways that provide good access to Memphis providers for residents of Shelby County and the vast rural areas surrounding it. Table Seven on the same page provides distances and drive times between this project and other LTACH's in the primary service area.

Table Six: Mileage and Drive Times Between Project and Major Communities in the 17-County Primary Service Area			
Community	**County and State**	**Distance in Miles**	**Drive Time in Minutes**
1. Marion	Crittenden, AR	29.8	32"
2. Forrest City	Saint Francis, AR	65.2	64"
3. Corinth	Alcorn, MS	82.0	87"
4. Senatobia	DeSoto, MS	22.2	28"
5. Oxford	Lafayette, MS	70.6	83"
6. Tupelo	Lee, MS	101.0	99"
7. Holly Springs	Marshall, MS	40.1	46"
8. Batesville	Panola, MS	67.1	65"
9. Senatobia	Tate, MS	44.,8	46"
10. Dyersburg	Dyer, TN	77.5	100"
11. Somerville	Fayette, TN	42.2	44"
12. Trenton	Gibson, TN	89.7	102"
13. Ripley	Lauderdale, TN	55.5	78"
14. Jackson	Madison, TN	77.8	77"
15. Selmer	McNairy, TN	83.7	102"
16. Memphis	Shelby, TN	--	--
17. Covington	Tipton, TN	40.6	59"

Source: Google Maps, Dec. 2013

Table Seven: Mileage and Drive Times Between Project and the Three Other Approved Long Term Acute Care Hospitals in the 17-County Primary Service Area			
Facility and Address	**County and State**	**Distance in Miles**	**Drive Time in Minutes**
Select Specialty Hospital 5959 Park Avenue, Memphis, TN 38119	Shelby, TN	na	na
Baptist Memorial Restorative Care Hospital 2100 Exeter Road, Memphis, TN 38138*	Shelby, TN	3.1	5"
Methodist Extended Care Hospital 225 South Claybrook, Memphis, TN 38104	Shelby, TN	16.2	19"
Memphis Long Term Care Specialty Hospital 877 Jefferson Ave., Memphis, TN 38103	Shelby, TN	11.0	22"

Source: Google Maps, Dec. 2013

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

C(I) NEED

C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.

A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.

B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria: Long Term Acute Care Hospital (LTACH) Beds

A. Need

1. The Need for long term care hospital (LTH) beds shall be determined by applying the guidelines of (0.5) beds per 10,000 population in the service area of the proposal.

Response: Tables Eight-A and -B, beginning on the next page, present the above calculation based on CY2013 and CY2015 population projections for the primary and secondary service area counties.

The Tennessee population data are from the Tennessee Department of Health (Feb. 2008 series). The 2013 and 2015 Mississippi and Arkansas projections are made from U.S. Census data, based on annual increases projected by the Census between 2010 and 2011. The applicant used Census data for those States because neither has annual projections by county, that incorporate the 2010 U.S. Census data.

The tables indicate a total area population of 2,433,814 persons in CY2015 (Year Two of this project). Despite the Memphis LTACHs' extraordinarily high utilization (averaging 86.3%), the projection formula in this criterion A.1 indicates no additional LTACH bed need beyond currently operational and approved beds. This seems to conflict with the logical implications of Criterion A.2 immediately below, which suggests that additional beds may be needed once the service area's average LTACH occupancy reaches 85%--which this area consistently exceeds.

2. If the project is a bed addition, existing long term care hospital beds must have a minimum average occupancy of 85%.

Response: The three LTACH's in the service area reported a combined occupancy of 86.3% in the most recent reporting year; two of the three exceeded 86% and Select had a 94.6% occupancy. For the lowest-occupancy facility, its 75.5% occupancy rate needs an average daily census of only 2.8 patients to be at 85% occupancy, due to its very small bed complement.

3. The population shall be the current year's population, projected two years forward.

Response: The applicant's analysis for Criterion A.1 above did use the service area population projected two years from the effective date on which this application will begin its review process (i.e., CY2013 population projected to CY2015).

Table Eight-A: LTACH Bed Need, Guidelines for Growth 2000 Service Area of Select Specialty Hospital		
CY2015 Population	**LTACH Bed Need @ 0.5 per 10,000 Population**	**LTACH Beds Existing or Approved**
2,433,814	122 beds	105 + 24 u.c. = 129 beds

Table Eight-B : LTACH Bed Need, Guidelines for Growth 2000 Service Area of Select Specialty Hospital					
County	State	2010	2011	2013	2015
Shelby Co	TN	938,186	943,681	956,126	970,591
Benton Co	TN	16,657	16,680	16,779	16,903
Carroll Co	TN	29,631	29,734	29,970	30,243
Chester Co	TN	16,645	16,760	17,031	17,322
Crockett Co	TN	14,944	15,063	15,336	15,664
Decatur Co	TN	11,516	11,494	11,509	11,546
Dyer Co	TN	38,716	38,865	39,238	39,682
Fayette Co	TN	38,247	38,728	39,818	41,105
Gibson Co	TN	48,956	49,061	49,303	49,637
Hardeman Co	TN	29,491	29,738	30,299	30,941
Hardin Co	TN	26,741	26,846	27,091	27,402
Haywood Co	TN	19,662	19,678	19,786	19,949
Henderson Co	TN	27,584	27,767	28,170	28,626
Henry Co	TN	32,394	32,525	32,834	33,179
Lake Co	TN	7,423	7,407	7,393	7,386
Lauderdale Co	TN	27,888	28,127	28,641	29,220
Madison Co	TN	99,334	100,059	101,634	103,431
McNairy Co	TN	26,161	26,251	26,476	26,722
Obion Co	TN	32,626	32,675	32,839	33,061
Tipton Co	TN	61,300	62,102	63,857	65,839
Weakly Co	TN	33,799	33,841	33,970	34,152
Total TN		**1,577,901**	**1,587,082**	**1,608,100**	**1,632,601**
Alcorn Co	MS	37,057	37,052	37,042	37,032
Benton Co	MS	8,729	8,732	8,738	8,744
Coahoma Co	MS	26,151	25,913	25,437	24,961
DeSoto Co	MS	161,252	164,053	169,655	175,257
Itawamba Co	MS	23,401	23,332	23,194	23,056
Lafayette Co	MS	47,354	48,472	50,708	52,944
Lee Co	MS	82,910	84,156	86,648	89,140
Marshall Co	MS	37,144	36,786	36,070	35,354
Panola Co	MS	34,704	34,602	34,398	34,194
Pontotoc Co	MS	29,957	29,900	29,786	29,672
Prentiss Co	MS	25,276	25,330	25,438	25,546
Tate Co	MS	28,886	28,719	28,385	28,051
Tippah Co	MS	22,232	22,143	21,965	21,787
Tishomingo Co	MS	19,593	19,603	19,623	19,643
Tunica Co	MS	10,778	10,628	10,328	10,028
Union Co	MS	27,134	27,340	27,752	28,164
Total MS		**622,558**	**626,761**	**635,167**	**643,573**
Crittenden Co	AR	50,902	50,525	49,771	49,017
Lee Co	AR	10,424	10,326	10,130	9,934
Mississippi Co	AR	46,480	45,966	44,938	43,910
Monroe Co	AR	8,149	8,075	7,927	7,779
Phillips Co	AR	21,757	21,442	20,812	20,182
St Francis Co	AR	28,258	27,970	27,394	26,818
Total AR		**165,970**	**164,304**	**160,972**	**157,640**
Total Service Area		**2,366,429**	**2,378,147**	**2,404,239**	**2,433,814**

1 MS & AR 2010 & 2011 Data From State & County Quickfacts,
U.S. Census Bureau, 2012; 2013 & 2015 based on straight-line projections.

2 TN Projections from Tennessee Dept of Health.

4. The primary service area cannot be smaller than the applicant's Community Services Area (CSA). If LTH beds are proposed within an existing hospital, CSA's served by the existing facility can be included along with consideration for populations in adjacent States, when the applicant provides documentation (such as admission sources from the Joint Annual Report).

Response: The applicant has conformed its West Tennessee service area to the boundaries of the West Tennessee CSA's, almost all of whose counties are in the applicant's admissions-based service area anyway. Counties in Mississippi and Arkansas are included based on actual admissions from those out-of-State counties.

B. Economic Feasibility

1. The payer costs of a long term hospital should demonstrate a substantial saving, or the services should provide additional benefit to the patient over the payer cost or over the provision of short term general acute care alternatives, treating a similar patient mix of acuity.

Response: Table Nine on the next page compares the applicant's current gross charges per patient day to those of other LTACH hospitals in Shelby County. Charge per stay information is not relevant because of the wide variation in lengths of stay between the two types of hospital. Acuity information is not available. The difference in gross charge per patient day between LTACH's and general acute care (short term) hospitals is clearly substantial.

Table Nine: Comparative Charges Per Patient Day In Shelby County LTACH Facilities 2011 Joint Annual Reports / CN1210-052 (Mem.LT Care Spec'y)			
LONG TERM ACUTE CARE HOSPITALS	**Gross Patient Charges in 2011**	**Days**	**Gross Charge Per Day**
Select Specialty CY 2011	$55,365,667	13,469	$4,111
Select Specialty CY 2015	$100,672,847	21,535	$4,675
Baptist Restorative Care CY2011	$44,353,983	8,267	$5,365
Methodist Extended Care CY2011	$37,557,166	11,337	$3,313
Memph LT Care Specialty CY2015	$28,143,153	8,322	$3,382

2. The payer costs should be such that the facility will be financially accessible to a wide range of payers as well as to adolescent and adult patients of all ages.

Response: Adult (18+ years of age) patients enrolled in commercial, Medicare, and Medicaid insurance programs are served by this facility. Following is the payor mix of this facility, for CY2011 and YTD 2012.

Table Ten: Select Specialty Hospital-Memphis Payor Mix 2011 & YTD 2012		
Payor Classification	**CY2011**	**Q1-Q3, CY 2012**
Medicare	80.02%	79.39%
Medicaid	3.33%	3.40%
Commercial & WC	15.48%	16.74%
Other	1.17%	0.47%

Source: Select Specialty Corp. records

3. Provisions will be made so that a minimum of 5% of the patient population using long term care beds will be charity or indigent care.

Response: Line C.2 of the applicant's Historic and Projected Data Charts for the project do not reflect charity care to uninsured or underinsured persons per se, but the applicant does provide a substantial amount of uncompensated care.

Select Medical Corporation (the parent company) and its hospitals use the term "FLO" days (meaning "fixed loss outliers") to record these uncompensated days of care. Here is how uncompensated care is calculated: Each patient is assigned a Medicare DRG code at admission. That DRG has a specified payment, and has certain statistics considered normative based on national experience with that DRG. One statistic is the DRG's "geometric length of stay" ("GLOS")--the days of care that Medicare decides is appropriate for that DRG. The hospital is reimbursed at cost (calculated from its annual Medicare Cost Report) for each day of care provided, from admission until a patient stays 5/6 of that DRG's GLOS. At that point, the balance of the DRG is paid to the hospital. After that, if a patient needs more inpatient care beyond the 5/6 point, the hospital receives no reimbursement for a "fixed loss period" for that patient--similar to the "donut hole" for individual Medicare drug plans. The fixed loss is a specific dollar amount of free care that Medicare requires the hospital to provide before it resumes payments on

that patient. And once it does, Medicare begins to reimburse only at 80% of the hospital's cost of care—which further increases the free care by the hospital.

While this is not technically "charity" care, it is a necessary and substantial amount of free days of care contributed to many long-stay patients regardless of income. This uncompensated care is a large annual figure for Select. In 2011, more than a fifth (21%) of Select's total days were not reimbursed due to the FLO uncompensated care window applied by Medicare and other payors. The data in Table ___ below show this facility's past three complete years of uncompensated days ("FLO days" that were incurrred. The Uncompensated Care column shows the applicant's gross charges during those days, minus any reimbursement later received for those patients after the fixed loss period ended. This is then shown as a percent of the hospital gross revenues. In the last full year (CY2011) Select provided this type of uncompensated care equal to 7.2% of hospital gross revenues. When 2012 data is compiled it will be similar to these years.

Table Eleven: Select Specialty Hospital-Memphis Uncompensated Care Days From FLO Process

Year	FLO (Fixed Loss Outlier) Days	Uncompensated Care	As a Percent of Gross Revenue	As a Percent of Total Facility Days
2009	2,406	$3,644,232	7.4%	17.9%
2010	2,500	$3,349,049	6.7%	19.7%
2011	2,846	$3,970,854	7.2%	21.1%

Source: Hospital management

C. Orderly Development

1. (a) Services offered by the long term hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional nursing (requiring 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

(b) Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

(c) Also, to avoid unnecessary duplication, the project should include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term hospitals.

Responses:

(a) Select Specialty complies with this. It is located within a 24-hour hospital with a full array of acute care physician specialties available and on-call.

YTD 2012, Select has provided an average of 9.64 nursing hours per patient day (PPD), and 3.23 hours of therapies PPD, for a total of 12.87 hours PPD of nursing and therapeutic services. This greatly exceeds the 6-8 hours PPD recommended in this criterion--and illustrates the serious care requirements of this patient population. (Please see the Attachment labeled "Miscellaneous" for monthly data in nursing and therapeutic hours, CY2011 and CY2012 YTD.)

(b) Select Specialty provides care for the types of patients listed in this criterion: hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

(c) Select Specialty Hospital-Memphis has never, and will never, provide the referenced services or any other services not appropriate for long term acute care hospitals.

2. The applicant should provide assurance that the facility's patient mix will exhibit an annual average aggregate length of stay greater than 25 days, as calculated by the Health Care Finance Administration (HCFA), and will seek licensure only as a hospital.

Response: Table Twelve below provides documentation that this hospital's ALOS exceeds 25 days, and is projected to continue to exceed 25 days. See column five of the table.

Table Twelve: Historical and Projected Utilization Select Specialty Hospital-Memphis 2009-2012 Annualized					
Year	**Beds**	**Admissions**	**Days**	**Average Length of Stay (ALOS)**	**Occupancy**
CY2009	39	464	13,473	29.0	94.6%
CY2010	39	426	12,680	29.8	89.1%
CY2011	39	418	13,469	32.2	94.6%
CY2012 (ann'd)	39	466	13,357	28.7	93.8%
4-year Average	**39**	**444**	**13,425**	**30.2**	**93.0%**
CY2013	49	534	15,527	28.6	85.3%
CY2014 Yr 1	77	677	19,345	28.6	68.8%
CY2015 Yr 2	77	753	21,535	28.6	76.6%
CY2016 Yr 3	77	843	24,090	28.6	85.7%
CY2017 Yr 4	77	887	25,368	28.6	93.8%

Source: Joint Annual Reports; hospital records; management projections. Occupancy calculated on 365 days without leap year consideration. Admissions and ADC rounded.

3. The applicant should provide assurance that the projected caseload will require no more than three (3) hours per day of rehabilitation.

Response: Table Thirteen below provides nursing hours and rehabilitation hours per patient day for CY2011, and CY2012 YTD. Similar hours of rehabilitation PPD will be provided in the beds in this project. Monthly data for these calculations is provided in the Attachments (see "Miscellaneous").

Table Thirteen: Rehabilitation and Nursing Hours PPD Select Specialty Hospital-Memphis		
	Rehabilitation Hours Per Patient Day	**Nursing Hours Per Patient Day**
CY2011	3.23	9.64
CY2012 annualized	3.03	9.67

Source: Hospital records

4. Because of the very limited statewide need for long term care beds, and their overall high acuity of care, these beds should be allocated only to community service areas and be either inside or in close proximity to tertiary referral hospitals, to enhance physical accessibility to the largest concentration of services, patients, and medical specialists.

Response: The applicant is located within a CSA, is within a tertiary referral

hospital, and is within five miles of two other tertiary referral hospitals in Memphis—Baptist Hospital and Methodist Germantown.

5. In order to ensure that the beds and the facility will be used for the purpose certified, any Certificate of Need for a long term care hospital should be conditioned on the institution being certified by the Health Care Financing Administration as a long term hospital, and qualifying as PPS-exempt under applicable Federal guidelines. If such certification is received *(sic)* prior to the expiration date of the Certificate of Need, as provided in Tennessee Code Annotated(TCA) Section 68-11-108(c), the Certificate of Need shall expire, and become null and void.

Response: This condition is already met. The applicant is presently certified as a long-term hospital and qualified as PPS-exempt.

CMS is the Federal Center for Medicare/Medicaid Services; replacement for HCFA) In 2008, CMS placed a moratorium on Medicare certification of additional LTACH beds nationwide. This was extended once and is now scheduled to expire December 29, 2012. The Medicare moratorium may or may not be extended; but the applicant sees that as irrelevant to a CON decision on this application, because it is unpredictable and because Tennessee can license the beds it chooses regardless of the changing landscape in Medicare reimbursement. Providers should be enabled to use needed beds as soon as the moratorium is lifted, and not have to wait many months after that date, to complete a CON process. This problem can be resolved by granting a CON to operate additional licensed beds conditional on expiration of any CMS moratorium on certification of those beds.

The Framework for Tennessee's Comprehensive State Health Plan

Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.

Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

Select Specialty Hospital is one of only three existing LTACH providers that together operate 105 beds to serve patients of 43 counties in Tennessee and adjoining States. All three facilities serve an important role in working with general short term hospitals to relieve the latter of the financial burden of providing weeks of costly, uncompensated care to patients who need acute care beyond what the DRG will cover during a short term acute care stay. Individually, all of these three facilities operated at between approximately 85% and 95% occupancy in some, or all, of the past three years; and their most recently reported combined occupancy in CY2011 exceeded 86%. Select operated at 93.6% occupancy in CY2012, and had to defer many requests for admission. Collaboration with short term hospitals, to reduce costs of overall hospital care, requires available beds at the LTACH chosen by the patient and the discharging physician. This project supports that collaboration and supports this criterion of the State Health Plan.

2. Access to Care

Every citizen should have reasonable access to health care.

Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

The applicant believes that reasonable access to care requires some measure of choice for consumers and their families and physicians, and inpatient choice cannot occur without available bed space among a reasonable number of hospitals that are physically

and financially accessible. By allowing Select to license these proposed beds, access will be improved by the expansion of patient choice for residents of a vast service area of more than two million population. Current limitations of bed supply reduce patients' choices below what was available before area LTACH's became full.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

This project encourages the competition and efficiency goals of this criterion. It is efficient in that it avoids new hospital bed construction, relying instead on inexpensive renovation of existing beds that adjoin its existing facility. It promotes appropriate competition by recognizing and enabling the LTACH provider most in demand by area physicians and patients--a provider that has been full for four years now, and is appropriately seeking to expand.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

Select Specialty Hospital complies with quality standards and practices of the licensure program of the State of Tennessee and of its Joint Commission accreditation program.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

Select Specialty Hospital, like other hospitals, contributes to the education of health care professionals by its affiliations for training students in programs at several colleges and universities in Tennessee. See Section C.III. (6) of this application.

C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

This facility does not prepare formal long-range development plans.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

Select Specialty Hospital is the largest LTACH in Memphis. Like the tertiary Memphis hospital systems that provide many of its admissions, it serves a wide region of counties in several States around Memphis.

Select Specialty Hospital's admissions data indicate that it served residents of 78 counties in Tennessee, Mississippi, Arkansas, and eight other States. Its primary service area consisted of 17 contiguous counties in Tennessee, Arkansas, and Mississippi, whose residents generated 85% of its admissions. Its secondary service area consisted of another 26 contiguous counties in those States, generating another 11.2% of its admissions. Together, its primary and secondary service areas totaled 43 contiguous counties generating 96.3% of its admissions. Another 3.7% of admissions originated in 35 other non-contiguous counties in eight States.

The 43-county primary and secondary service areas are shown in Map One on the following page. The heaviest shaded counties are the primary service area; the lighter shaded counties are the secondary service area. The number of admissions from each county in the study period is shown. Following Map One, Table Fourteen lists the total service area counties.

With only a few exceptions, counties of fewer than 4 admissions were excluded from the primary and secondary service areas. Crockett and Chester Counties in West Tennessee were included in the declared project service area, because they are surrounded by service area counties and their inclusion is a reasonable and customary health planning practice when constructing a map of a project's contiguous service area counties. Also, those two counties plus Henry, Benton, and Decatur Counties in West Tennessee were included because Guideline for Growth #4 for LTACH beds requires inclusion of entire Tennessee CSA's (Community Service Areas) whose counties are being served.

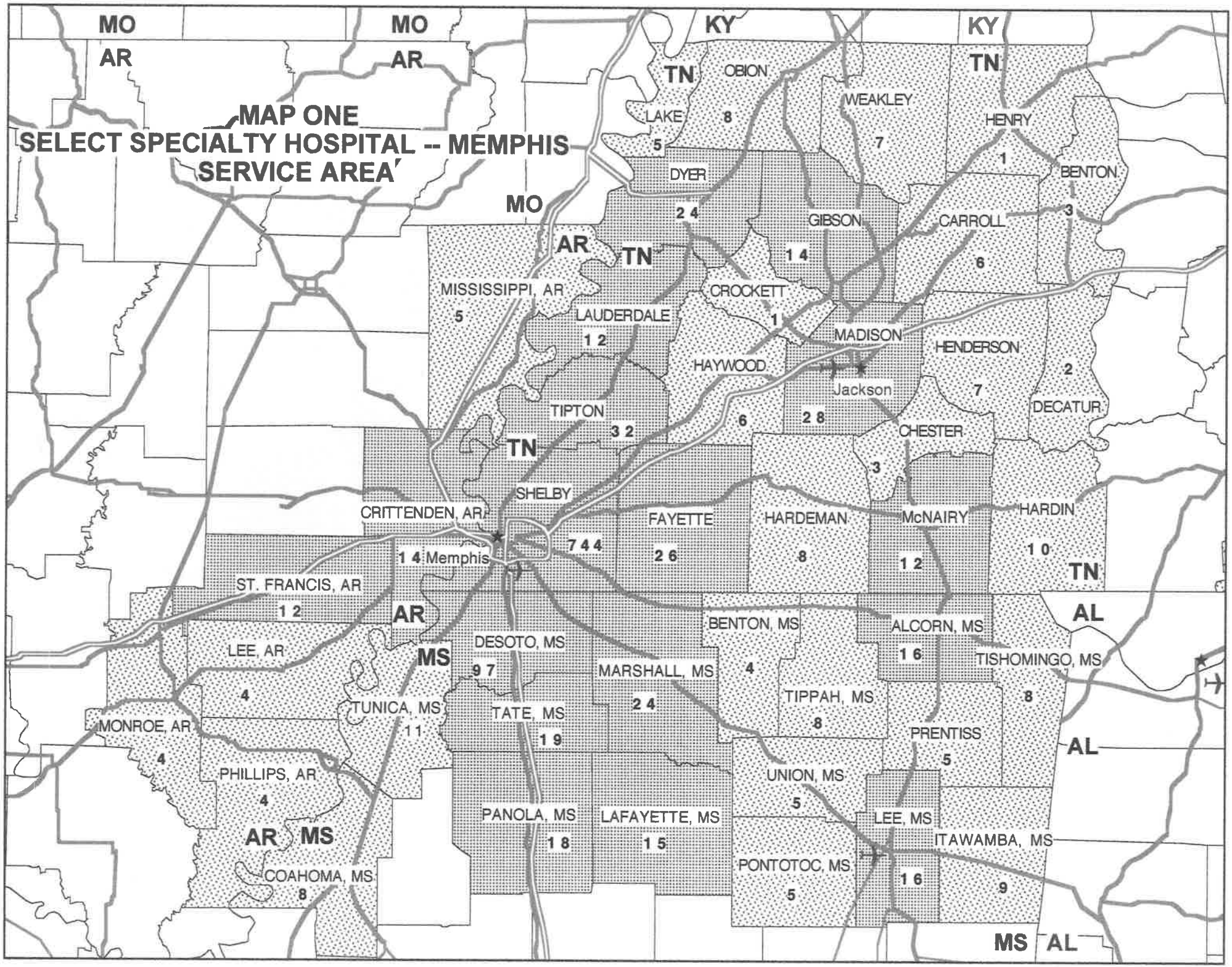
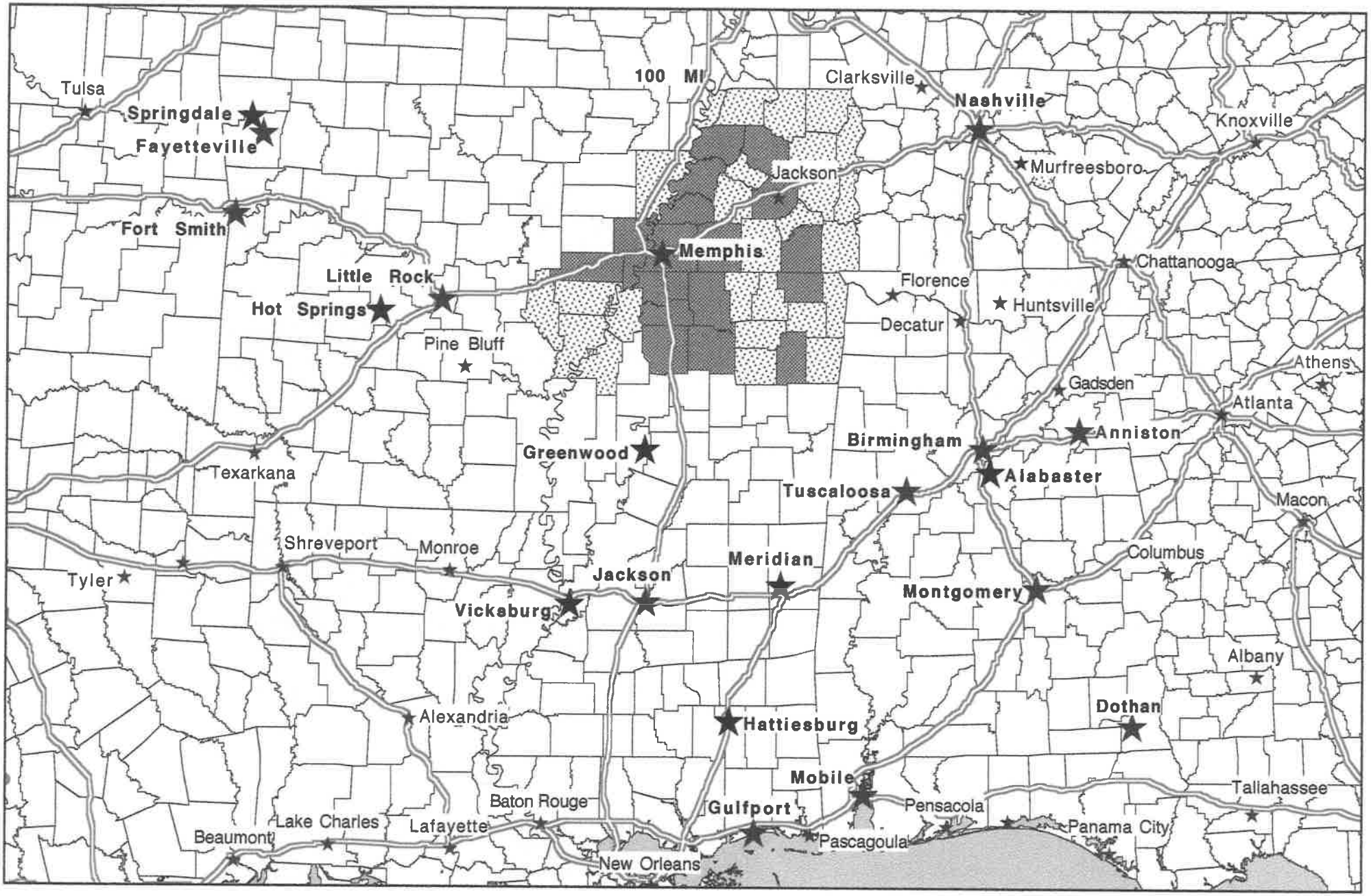

MAP ONE
SELECT SPECIALTY HOSPITAL -- MEMPHIS
SERVICE AREA
MO
AR
KY
TN
MS
AL
OBION
8
LAKE
5
WEAKLEY
7
HENRY
1
BENTON
3
DYER
24
GIBSON
14
CARROLL
6
MISSISSIPPI, AR
5
LAUDERDALE
12
CROCKETT
1
MADISON
HENDERSON
2
HAYWOOD
6
Jackson
28
7
DECATUR
TIPTON
32
CHESTER
3
SHELBY
CRITTENDEN, AR
FAYETTE
26
HARDEMAN
8
McNAIRY
12
HARDIN
10
744
14 Memphis
ST. FRANCIS, AR
12
BENTON, MS
ALCORN, MS
16
TISHOMINGO, MS
8
LEE, AR
4
DESOTO, MS
97
MARSHALL, MS
24
4
TIPPAH, MS
8
TUNICA, MS
11
TATE, MS
19
MONROE, AR
4
PRENTISS
5
PHILLIPS, AR
4
UNION, MS
5
PANOLA, MS
18
LAFAYETTE, MS
15
LEE, MS
ITAWAMBA, MS
PONTOTOC, MS
5
16
9
COAHOMA, MS
8

Table Fourteen: Service Area
For Select Specialty Hospital-Memphis

Counties Ranked By Admissions					Alphabetic By State and County		
Primary Service Area		Discharges	Cumulative	Percent of Total	Primary Service Area		
SHELBY, TENNESSEE	TN	744	744	56.1%	CRITTENDEN, ARKANSAS	AR	14
DESOTO, MISSISSIPPI	MS	97	841	63.8%	SAINT FRAN, ARKANSAS	AR	12
TIPTON, TENNESSEE	TN	32	873	66.2%	ALCORN, MISSISSIPPI	MS	16
MADISON, TENNESSEE	TN	28	901	68.3%	DESOTO, MISSISSIPPI	MS	97
FAYETTE, TENNESSEE	TN	26	927	70.3%	LAFAYETTE, MISSISSIPPI	MS	15
MARSHALL, MISSISSIPPI	MS	24	951	72.1%	LEE, MISSISSIPPI	MS	16
DYER, TENNESSEE	TN	24	975	73.9%	MARSHALL, MISSISSIPPI	MS	24
TATE, MISSISSIPPI	MS	19	994	75.4%	PANOLA, MISSISSIPPI	MS	18
PANOLA, MISSISSIPPI	MS	18	1012	76.7%	TATE, MISSISSIPPI	MS	19
ALCORN, MISSISSIPPI	MS	16	1028	77.9%	DYER, TENNESSEE	TN	24
LEE, MISSISSIPPI	MS	16	1044	79.2%	FAYETTE, TENNESSEE	TN	26
LAFAYETTE, MISSISSIPPI	MS	15	1059	80.3%	GIBSON, TENNESSEE	TN	14
CRITTENDEN, ARKANSAS	AR	14	1073	81.3%	LAUDERDALE, TENNESSEE	TN	12
GIBSON, TENNESSEE	TN	14	1087	82.4%	MADISON, TENNESSEE	TN	28
SAINT FRAN, ARKANSAS	AR	12	1099	83.3%	MCNAIRY, TENNESSEE	TN	12
LAUDERDALE, TENNESSEE	TN	12	1111	84.2%	SHELBY, TENNESSEE	TN	744
MCNAIRY, TENNESSEE	TN	12	1123	85.1%	TIPTON, TENNESSEE	TN	32
Secondary Service Area					**Secondary Service Area**		
TUNICA, MISSISSIPPI	MS	11	1134	86.0%	LEE, ARKANSAS	AR	4
HARDIN, TENNESSEE	TN	10	1144	86.7%	MISSISSIPP, ARKANSAS	AR	5
ITAWAMBA, MISSISSIPPI	MS	9	1153	87.4%	MONROE, ARKANSAS	AR	4
COAHOMA, MISSISSIPPI	MS	8	1161	88.0%	PHILLIPS, ARKANSAS	AR	4
TIPPAH, MISSISSIPPI	MS	8	1169	88.6%	BENTON, MISSISSIPPI	MS	4
TISHOMINGO, MISSISSIPPI	MS	8	1177	89.2%	COAHOMA, MISSISSIPPI	MS	8
HARDEMAN, TENNESSEE	TN	8	1185	89.8%	ITAWAMBA, MISSISSIPPI	MS	9
OBION, TENNESSEE	TN	8	1193	90.4%	PONTOTOC, MISSISSIPPI	MS	5
HENDERSON, TENNESSEE	TN	7	1200	91.0%	PRENTISS, MISSISSIPPI	MS	5
WEAKLEY, TENNESSEE	TN	7	1207	91.5%	TIPPAH, MISSISSIPPI	MS	8
CARROLL, TENNESSEE	TN	6	1213	92.0%	TISHOMINGO, MISSISSIPPI	MS	8
HAYWOOD, TENNESSEE	TN	6	1219	92.4%	TUNICA, MISSISSIPPI	MS	11
MISSISSIPP, ARKANSAS	AR	5	1224	92.8%	UNION, MISSISSIPPI	MS	5
PONTOTOC, MISSISSIPPI	MS	5	1229	93.2%	BENTON, TENNESSEE	TN	3
PRENTISS, MISSISSIPPI	MS	5	1234	93.6%	CARROLL, TENNESSEE	TN	6
UNION, MISSISSIPPI	MS	5	1239	93.9%	CHESTER, TENNESSEE	TN	3
LAKE, TENNESSEE	TN	5	1244	94.3%	CROCKETT, TENNESSEE	TN	1
LEE, ARKANSAS	AR	4	1248	94.6%	DECATUR, TENNESSEE	TN	2
PHILLIPS, ARKANSAS	AR	4	1252	94.9%	HARDEMAN, TENNESSEE	TN	8
BENTON, MISSISSIPPI	MS	4	1256	95.2%	HARDIN, TENNESSEE	TN	10
MONROE, ARKANSAS	AR	4	1260	95.5%	HAYWOOD, TENNESSEE	TN	6
BENTON, TENNESSEE	TN	3	1263	95.8%	HENDERSON, TENNESSEE	TN	7
CHESTER, TENNESSEE	TN	3	1266	96.0%	HENRY, TENNESSEE	TN	1
DECATUR, TENNESSEE	TN	2	1268	96.1%	LAKE, TENNESSEE	TN	5
CROCKETT, TENNESSEE	TN	1	1269	96.2%	OBION, TENNESSEE	TN	8
HENRY, TENNESSEE	TN	1	1270	96.3%	WEAKLEY, TENNESSEE	TN	7
Tertiary Service Area							
CRAIGHEAD, ARKANSAS	AR	3	1273	96.5%			
GRENADA, MISSISSIPPI	MS	3	1276	96.7%			
YALOBUSHA, MISSISSIPPI	MS	3	1279	97.0%			
CROSS, ARKANSAS	AR	2	1281	97.1%			
GREENE, ARKANSAS	AR	2	1283	97.3%			
POINSETT, ARKANSAS	AR	2	1285	97.4%			
CALHOUN, MISSISSIPPI	MS	2	1287	97.6%			
CHICKASAW, MISSISSIPPI	MS	2	1289	97.7%			
CLAY, MISSISSIPPI	MS	2	1291	97.9%			
WASHINGTON, MISSISSIPPI	MS	2	1293	98.0%			
COOK, ILLINOIS	OTHER-IL	2	1295	98.2%			
CLAY, ARKANSAS	AR	1	1296	98.3%			
CLEBURNE, ARKANSAS	AR	1	1297	98.3%			
JEFFERSON, ARKANSAS	AR	1	1298	98.4%			
LONOKE, ARKANSAS	AR	1	1299	98.5%			
MARION, ARKANSAS	AR	1	1300	98.6%			
WHITE, ARKANSAS	AR	1	1301	98.6%			
FULTON, KENTUCKY	KY	1	1302	98.7%			
JEFFERSON, KENTUCKY	KY	1	1303	98.8%			
BOLIVAR, MISSISSIPPI	MS	1	1304	98.9%			
HINDS, MISSISSIPPI	MS	1	1305	98.9%			
JONES, MISSISSIPPI	MS	1	1306	99.0%			
LEFLORE, MISSISSIPPI	MS	1	1307	99.1%			
LOWNDES, MISSISSIPPI	MS	1	1308	99.2%			
MONTGOMERY, MISSISSIPPI	MS	1	1309	99.2%			
OKTIBBEHA, MISSISSIPPI	MS	1	1310	99.3%			
QUITMAN, MISSISSIPPI	MS	1	1311	99.4%			
PERSON, NORTH CAROLINA	NC	1	1312	99.5%			
BROWARD, FLORIDA	OTHER-FL	1	1313	99.5%			
OAKLAND, MICHIGAN	OTHER-MI	1	1314	99.6%			
HOWELL, MISSOURI	OTHER-MO	1	1315	99.7%			
CUMBERLAND, NORTH CAROLINA	OTHER-NC	1	1316	99.8%			
DICKSON, TENNESSEE	TN	1	1317	99.8%			
RUTHERFORD, TENNESSEE	TN	1	1318	99.9%			
GIBSON, VIRGINIA	VA	1	1319	100.0%			

Source: Hospital records for CY2010-2012.



MAP TWO: LTACH LOCATIONS (LARGE STARS ONLY)
WEST TENNESSEE, ARKANSAS, MISSISSIPPI, & ALABAMA

The declared 43-county service area is also validated by the fact that residents of almost all of its counties are closer to Select Specialty Hospital, than they are to LTACH's elsewhere.

In West and Middle Tennessee, the only LTACH facilities are in Memphis and Nashville. Only three of the twenty-one West Tennessee counties in this project's declared 43-county service area have shorter drive times to Memphis than to Nashville. Similarly, all but two of the twenty-two Arkansas and Mississippi counties in the declared project service area are closer to Select Specialty Hospital than to LTACH's in their home states.

This is demonstrated by Table Fifteen on the following pages--listing the seventeen counties on the "perimeter" of the service area, which are closest to alternative LTACH's beyond this service area, in Nashville or adjoining States. Even in these perimeter counties, most residents have a shorter drive time to Memphis than to where the nearest alternative LTACH's are located. The shorter drive times for each comparison are bolded. And even for those few counties that are slightly closer to alternative LTACH's outside Memphis, there are special circumstances that justify their inclusion in a Memphis LTACH service area. Henry and Decatur County TN residents, for example, are much closer to Jackson tertiary care hospitals than to Nashville hospitals. If they seek hospital and specialty care in Jackson, many are more likely to be referred to Memphis than to Nashville, regardless of a small drive time differential. Similarly, Coahoma (Clarksdale) patients who typically seek care in Memphis will continue to drive the extra few miles to Memphis LTACH's than go to rural Mississippi for admission to the LTACH in rural Greenwood.

Further illustration that almost all these counties' access to Memphis is superior to their access to LTACH's in other locations is provided by Map Two on the second following page. Map Two has large stars marking the location of all alternative LTACH's in Mississippi, Arkansas, Alabama, and Middle and West Tennessee. (Small stars do not denote an LTACH). It can be seen that almost all the project service area counties are all closer to LTACH providers in Memphis than to LTACH's in any other city in these four States. Addresses of the alternative out-of-State LTACH's on Map Two are listed in the Attachments ("Miscellaneous").

Table Fifteen: Distance and Drive Times Between Counties on the Perimeter of the Project Service Area And The Closest Cities With Long Term Acute Care Hospitals								
			Cities With Alternative Long Term Acute Care Hospitals					
Service Area County (City)	**Select Spec'y in Memphis TN**		**Little Rock AR Cape Gir'x MO* Nashville TN****		**Greenwood MS**		**Jackson MS**	
	miles	minutes	miles	minutes	miles	minutes	miles	minutes
TENNESSEE								
Henry (Paris)*	132	139"	121	**122"****	--	--	--	--
Benton (Camden)*	136	**130"**	177	168"**	--	--	--	--
Decatur (Parsons)*	118	116"	97	**95"****	--	--	--	--
Hardin (Savannah)*	118	**124"**	118	126"**	--	--	--	
ARKANSAS								
Mississippi (Blytheville)*	68	**66"**	106"	102"*	--	--	--	--
Crittenden (Marion)					--	--	--	--
St. Francis (Forrest City)	65.2	**64"**	94.7	90"	--	--	--	--
Lee County (Marianna)	76.3	**83"**	99.5	104"	--	--	--	--
Monroe (Brinkley)	87.5	81"	69.1	**65"**	--	--	--	--
Phillips (Helena)	78.1	**88"**	122	129"	--	--	--	--
MISSISSIPPI								
Coahoma (Clarksdale)	83.8	96"	--	--	58	**69"**	155	169"
Panola (Batesville)	67.1	**65"**	--	--	71	74"	151	135"
Lafayette (Oxford)	70.6	**83"**	--	--	93.7	100"	173	160"
Pontotoc (Pontotoc)	92.7	**103"**	--	--	104	127"	125	137"
Lee (Tupelo)	101	**99"**	--	--	125	138"	190	189"
Itawamba (Fulton)	119	**119"**	--	--	148	160"	213	212"
Tishomingo (Luka)								

Source: Google Maps, December 2012

INSERT MAP TWO--THREE STATE MAP WITH LTACH CITIES STARRED

C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

As shown by Table Sixteen on the following page, the eight Tennessee counties in the applicant's primary service area have a population of 1.3 million persons, which will increase approximately 3% over the next four years. This growth rate is slightly below the State's average 3.4% population growth rate.

The Tennessee primary service area is slightly less aged, and will remain so through 2017--but the percent of its population that is elderly is growing faster than in the State as a whole (13.5% increase vs. 12.4% increase Statewide), which eventually would erase the difference.

The primary service area has a higher percent of its population enrolled in TennCare, and a higher percent of persons below the poverty level, than the State average.

Table Sixteen: Demographic Characteristics of TN Primary Service Area Counties Of Select Specialty Hospital-Memphis 2013-2017

Demographic	SHELBY	DYER	FAYETTE	GIBSON	LAUDERDALE	MADISON	McNAIRY	TIPTON	PRIMARY SERVICE AREA	STATE OF TENNESSEE
Median Age-2010 US Census										38.0
Total Population-2013	956,126	39,238	39,818	49,303	28,641	101,634	26,476	63,857	1,305,093	6,361,070
Total Population-2017	983,298	40,042	41,841	49,878	29,626	104,914	26,908	67,365	1,343,872	6,575,165
Total Population-% Change 2013 to 2017	2.8%	2.0%	5.1%	1.2%	3.4%	3.2%	1.6%	5.5%	3.0%	3.4%
Age 65+ Population-2013	103,296	5,910	5,960	8,634	3,937	13,277	4,910	7,541	153,465	878,496
% of Total Population	10.8%	15.1%	15.0%	17.5%	13.7%	13.1%	18.5%	11.8%	11.8%	13.8%
Age 65+ Population-2017	118,044	6,515	7,093	9,081	4,442	15,013	5,290	8,748	174,226	987,074
% of Population	12.0%	16.3%	17.0%	18.2%	15.0%	14.3%	19.7%	13.0%	13.0%	15.0%
Age 65+ Population-% Change 2013-2017	14.3%	10.2%	19.0%	5.2%	12.8%	13.1%	7.7%	16.0%	13.5%	12.4%
Median Household Income	$46,102	$38,909	$57,437	$37,577	$34,078	$40,667	$34,953	$50,869	$42,574	$43,314
TennCare Enrollees (08/12)	231,988	9,467	5,686	11,115	7,326	21,161	7,017	11,615	305,375	1,211,113
Percent of 2012 Population Enrolled in TennCare	24.3%	24.1%	14.3%	22.5%	25.6%	20.8%	26.5%	18.2%	23.4%	19.0%
Persons Below Poverty Level (2012)	192,181	7,534	4,659	8,825	7,246	19,514	5,957	9,770	255,686	1,049,577
Persons Below Poverty Level As % of Population (US Census)	20.1%	19.2%	11.7%	17.9%	25.3%	19.2%	22.5%	15.3%	18.9%	16.5%

Sources: TDH Population Projections, Feb. 2008; U.S. Census QuickFacts and FactFinder2;
TennCare Bureau. PSA data is unweighted average or total of county data.
NR means not reported in U.S. Census source document.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

The service area population does not seem to have special care needs differing from those in other areas of Tennessee. Of all patients discharged from short term acute care stays in service area hospitals, there are always a small number who do not thrive. They require prolonged additional care in an acute care facility-- e.g., a "long term" acute care facility. Their stays average between three and four weeks, in accordance with Medicare expectations. The great majority (4 out of 5) are elderly, vulnerable, Medicare patients.

This project meets those patients' needs. Existing LTACH beds that serve this area are highly occupied, and have been highly occupied for at least four years. A newly approved Memphis LTACH, not yet under construction, seems to be ensured of immediate full occupancy, by patients in its host facility who have not been seeking admission to LTACH beds. The applicant believes that more LTACH beds are needed by residents in rural sectors of this service area. The project will provide needed care to such persons.

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

Table Seventeen on the following page presents 2009-2011 Joint Annual Report utilization data filed with the Department of Health by the three LTACH facilities in the service area. They are all in Memphis. The table provides licensed beds, admissions, patient/discharge days, ALOS, ADC, and occupancy for each facility, as well as the averages of those statistics for each year. Utilization of the LTACH provider group, led by Select Specialty, was very strong over the past three years. The most recent reported data for 2011 shows that:

- The average occupancy for service area LTACH's was 86.3% on licensed beds.

- That exceeds the Guidelines for Growth Criterion A.2 which recommends 85% areawide LTACH occupancy before additional LTACH beds are approved.

- Select's occupancy was the highest, at 94.6% of licensed beds.

- The second highest occupancy reported was 86.3%.

- Even the lowest occupancy facility reported almost 76% utilization.

Table Seventeen: Bed Utilization in Primary Service Area 2009-2011

2009 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Select Specialty Hospital--Memphis	Shelby	39	464	13,473	29	37	94.6%
	Baptist Memorial Restorative Care Hospital	Shelby	30	240	9,331	39	26	85.2%
	Methodist Extended Care Hospital	Shelby	36	425	11,757	28	32	89.5%
	SERVICE AREA TOTALS		**105**	**1,129**	**34,561**	31	95	90.2%

2010 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Select Specialty Hospital--Memphis	Shelby	39	426	12,680	30	35	89.1%
	Baptist Memorial Restorative Care Hospital	Shelby	30	236	8,015	34	22	73.2%
	Methodist Extended Care Hospital	Shelby	36	419	11,379	27	31	86.6%
	SERVICE AREA TOTALS		**105**	**1,081**	**32,074**	30	88	83.7%

2011 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Select Specialty Hospital--Memphis	Shelby	39	418	13,469	32	37	94.6%
	Baptist Memorial Restorative Care Hospital	Shelby	30	207	8,267	40	23	75.5%
	Methodist Extended Care Hospital	Shelby	36	434	11,337	26	31	86.3%
	SERVICE AREA TOTALS		**105**	**1,059**	**33,073**	31	91	86.3%

C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION. THE METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

Table Eighteen below shows the facility's historical utilization 2009-2012, and management's projections for its utilization through CY2017, which will be Year Four of this project. Select Specialty Hospital management has experienced extraordinarily high demand for its beds for the past four years, averaging 93% occupancy on 39 beds. Due to lack of bed space, Select has had to deny requests for qualified admissions during 17 of the past 22 months. Select does not maintain logs of "unduplicated patient" admissions requests. But during most months, an average of a dozen requests for admissions must be deferred for lack of bed space.

As Select expands its outreach marketing in Mississippi, Arkansas, and rural West Tennessee in CY2013, additional admissions demand is predictable. With its proposed additional beds, Select projects that between 2012 and 2015 (Year Two) its admissions will increase by an average of approximately 96 new admissions per year, and its average daily census will increase by an average of approximately 7 per year.

Table Eighteen: Historical and Projected Utilization
Select Specialty Hospital-Memphis
2009-2012 Annualized

Year	Beds	Admissions	Days	Average Daily Census	Occupancy
CY2009	39	464	13,473	37	94.6%
CY2010	39	426	12,680	35	89.1%
CY2011	39	418	13,469	37	94.6%
CY2012 (ann'd)	39	466	13,357	37	93.8%
4-year Average	**39**	**444**	**13,425**	**37**	**93.0%**
CY2013	49	534	15,527	43	85.3%
CY2014 Yr 1	77	677	19,345	53	68.8%
CY2015 Yr 2	77	753	21,535	59	76.6%
CY2016 Yr 3	77	843	24,090	66	85.7%
CY2017 Yr 4	77	887	25,368	70	93.8%

Source: Joint Annual Reports; hospital records; management projections. Occupancy calculated on 365 days without leap year consideration. Admissions and ADC rounded.

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

• ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST $3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.

• THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.

• THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.

• FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The letter supporting the construction cost estimate is being submitted to the Agency under separate cover, to be placed in Attachment C, Economic Feasibility--1.

On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the Development staff of Select Medical Corporation.

Line A.2, legal, administrative, and consultant fees, were estimated by the Development staff of Select Medical Corporation and the CON consultant.

Line A.5, construction cost, was estimated not to exceed $95 PSF for all clinical areas of the 11th floor (excluding elevators, etc.) This includes a construction contingency.

Line A.7 includes both fixed and moveable equipment costs, estimated by Select Medical Corporation's equipment planning staff.

Line A.9 includes such costs as miscellaneous minor equipment and furnishings, miscellaneous fees and overhead, IT, and telecommunications.

Line B.1 is the fair market value of the facility being leased, calculated in the two alternative ways required by staff rules. The market value of the space was the larger of these two alternative calculations and was used in the Project Cost Chart.

Lease Outlay Method:
5 years first lease extension term; additional rent for 28 beds = $2,421,184

Pro Rata Building Value Method:
$150 PSF estimated depreciated value X 21,677 SF leased = $3,251,550

PROJECT COSTS CHART--BED EXPANSION FOR SELECT SPECIALTY HOSPITAL MEMPHIS

A. Construction and equipment acquired by purchase:

1.	Architectural and Engineering Fees	6.5%xA.5	$ 133,855
2.	Legal, Administrative, Consultant Fees (Excl CON Filing)		55,000
3.	Acquisition of Site		0
4.	Preparation of Site		0
5.	Construction Cost	$95 PSF X 21,677 PSF	2,059,315
6.	Contingency Fund	in A.5	0
7.	Fixed Equipment (Not included in Construction Contract)		0
8.	Moveable Equipment (List all equipment over $50,000)		1,263,185
9.	Other (Specify) IT, telecommun, etc		120,000

B. Acquisition by gift, donation, or lease:

1.	Facility (inclusive of building and land)	3,251,550
2.	Building only	0
3.	Land only	0
4.	Equipment (Specify)	0
5.	Other (Specify)	0

C. Financing Costs and Fees:

1.	Interim Financing	0
2.	Underwriting Costs	0
3.	Reserve for One Year's Debt Service	0
4.	Other (Specify)	0

D. Estimated Project Cost (A+B+C) 6,882,905

E. CON Filing Fee 15,487

F. Total Estimated Project Cost (D+E) **TOTAL $** 6,898,392

Actual Capital Cost 3,646,842
Section B FMV 3,251,550

C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).

_____A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

_____B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

_____C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

_____D. Grants--Notification of Intent form for grant application or notice of grant award;

__x___E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

_____F. Other--Identify and document funding from all sources.

The project will be funded/financed by the hospital, from reserves available currently. Documentation of intent to finance is provided in Attachment C, Economic Feasibility--2. The hospital's income statement and balance sheet are also provided in the Attachments.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The justification of costs was provided in an earlier section, which is repeated below.

This project is more economical than most. By comparison, the estimated $2,059,315 remodeling/renovation cost for the project is projected to be only $95 PSF. The 2009-2011 acute care construction projects approved by the HSDA had the costs per SF shown in Table Three below. This project's $95 PSF cost is below even 1st quartile averages for renovation ($125 PSF).

Table Four: Hospital Construction Cost PSF
Years: 2009 – 2011

	Renovated Construction	New Construction	Total Construction
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$125.84/sq ft	$324.00/sq ft	$301.74/sq ft

Source: CON approved applications for years 2009 through 2011

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable. Select has provided Projected Data Charts for the 28 beds being requested, and also for the entire 77 bed facility when the 28 beds are opened. Itemization of the "other" expenses listed on both historical and projected charts is provided on a single sheet following the data charts.

HISTORICAL DATA CHART – SELECT SPECIALTY HOSPITAL MEMPHIS (39 BEDS)

Give information for the last three (3) years for which complete data are available for the facility or agency.

The fiscal year begins in JANUARY.

		CY 2009	CY2010	CY2011
A.	Utilization Data (JAR discharge days) & Occupancy	13,473 / 94.6%	12,680 / 89.1%	13,470 / 94.6%
B.	Revenue from Services to Patients			
1.	Inpatient Services	$ 48,966,179	50,227,911	55,365,667
2.	Outpatient Services			
3.	Emergency Services			
4.	Other Operating Revenue (rental & interest income)	79,722	25,093	23,599
	(Specify) See notes			
	Gross Operating Revenue	$ 49,045,901	$ 50,253,004	$ 55,389,266
C.	Deductions for Operating Revenue			
1.	Contractual Adjustments	$ 27,550,747	29,520,092	34,254,860
2.	Provision for Charity Care (see notes)			
3.	Provisions for Bad Debt	196,718	245,189	651,376
	Total Deductions	$ 27,747,465	$ 29,765,281	$ 34,906,236
NET OPERATING REVENUE		$ 21,298,436	$ 20,487,723	$ 20,483,030
D.	Operating Expenses			
1.	Salaries and Wages	$ 8,641,388	8,604,828	8,821,665
2.	Physicians Salaries and Wages	0	0	0
3.	Supplies	2,240,036	2,316,600	2,426,988
4.	Taxes	1,234,633	1,259,246	1,361,619
5.	Depreciation	147,159	105,836	79,709
6.	Rent	392,898	575,151	643,405
7.	Interest, other than Capital	1,234	0	0
8.	Management Fees			
	a. Fees to Affiliates	1,571,477	1,223,660	1,257,018
	b. Fees to Non-Affiliates	0	0	0
9.	Other Expenses (Specify) See notes	3,878,534	4,519,743	4,803,389
	Total Operating Expenses	$ 18,107,359	18,605,064	19,393,793
E.	Other Revenue (Expenses) -- Net (Specify)	$	$	$
NET OPERATING INCOME (LOSS)		$ 3,191,077	$ 1,882,659	$ 1,089,237
F.	Capital Expenditures			
1.	Retirement of Principal	$ 0	$ 0	$ 0
2.	Interest	0	0	0
	Total Capital Expenditures	$ 0	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ 3,191,077	$ 1,882,659	$ 1,089,237

PROJECTED DATA CHART—SELECT SPECIALTY HOSPITAL MEMPHIS (28 BEDS)

Give information for the two (2) years following the completion of this proposal.
The fiscal year begins in January.

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				Year 2014	Year 2015
			Admissions	143	218
A.	Utilization Data		Patient Days	4,088	6,241
B.	Revenue from Services to Patients				
	1.	Inpatient Services		$ 18,561,633	$ 29,145,658
	2.	Outpatient Services			
	3.	Emergency Services			
	4.	Other Operating Revenue (Specify)			
			Gross Operating Revenue	$ 18,561,633	$ 29,145,658
C.	Deductions for Operating Revenue				
	1.	Contractual Adjustments		$ 12,139,708	$ 19,260,772
	2.	Provision for Charity Care			
	3.	Provisions for Bad Debt		147,705	227,353
			Total Deductions	$ 12,287,413	$ 19,488,125
NET OPERATING REVENUE				$ 6,274,220	$ 9,657,533
D.	Operating Expenses				
	1.	Salaries and Wages		$ 2,524,940	$ 4,202,548
	2.	Physicians Salaries and Wages			
	3.	Supplies		683,120	1,046,201
	4.	Taxes	38.5% avg 09-11	171,224	321,213
	5.	Depreciation		313,099	313,100
	6.	Rent		442,585	455,863
	7.	Interest, other than Capital			
	8.	Management Fees			
		a. Fees to Affiliates	6% assumed	376,453	579,452
		b. Fees to Non-Affiliates			
	9.	Other Expenses (Specify)	See notes	1,489,285	2,226,050
			Total Operating Expenses	$ 6,000,706	$ 9,144,427
E.	Other Revenue (Expenses) -- Net (Specify)			$	$
NET OPERATING INCOME (LOSS)				$ 273,514	$ 513,106
F.	Capital Expenditures				
	1.	Retirement of Principal		$	$
	2.	Interest			
			Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES				$ 273,514	$ 513,106

PROJECTED DATA CHART--SELECT SPECIALTY HOSPITAL MEMPHIS (77 BEDS)

Give information for the two (2) years following the completion of this proposal.
The fiscal year begins in January.

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			Year 2014	Year 2015
		Admissions	677	753
A.	Utilization Data	Patient Days	19,345	21,535
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 87,875,704	$ 100,672,847
	2. Outpatient Services			
	3. Emergency Services			
	4. Other Operating Revenue (Specify)			
		Gross Operating Revenue	$ 87,875,704	$ 100,672,847
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 57,572,330	$ 66,547,039
	2. Provision for Charity Care			
	3. Provisions for Bad Debt		696,978	784,894
		Total Deductions	$ 58,269,308	$ 67,331,933
NET OPERATING REVENUE			$ 29,606,396	$ 33,340,914
D.	Operating Expenses			
	1. Salaries and Wages		$ 13,053,243	$ 14,860,264
	2. Physicians Salaries and Wages			
	3. Supplies		3,405,684	3,786,145
	4. Taxes	38.5% avg 09-11	871,781	1,046,702
	5. Depreciation		458,291	472,577
	6. Rent		1,217,585	1,254,113
	7. Interest, other than Capital			
	8. Management Fees			
	a. Fees to Affiliates	6% assumed	1,776,384	2,000,455
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes	7,430,843	8,248,654
		Total Operating Expenses	$ 28,213,811	$ 31,668,910
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 1,392,585	$ 1,672,004
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 1,392,585	$ 1,672,004

Other Expenses (Line D.8)	HISTORICAL 39 BEDS			PROJECTION 28 BEDS				PROJECTION 77 BEDS			
	2009	2010	2011	Year 1	Year 2	Year 3	Year 4	Year 1	Year 2	Year 3	Year 4
Insurance	90,177	103,968	114,612	24,581	44,212	65,407	73,703	155,678	176,687	198,949	209,799
Utilities	28,729	25,870	32,564	60,984	62,839	64,750	66,719	162,624	177,709	183,114	198,822
Legal & Accounting	47,872	43,931	37,401	10,286	18,501	27,370	30,842	65,146	73,937	83,253	87,794
Repairs & Maintenance	135,452	255,634	114,629	40,261	72,415	107,130	120,718	254,985	289,396	325,859	343,631
Travel/Meals & Entertainment	230,685	223,143	225,357	54,071	97,256	143,878	162,127	342,451	388,665	437,636	461,504
Contracted Physicians	72,620	66,215	146,606	22,724	40,874	60,468	68,137	143,922	163,344	183,925	193,956
Ancillary Patient Services	2,699,937	3,072,318	3,357,487	1,044,527	1,603,788	2,225,401	2,515,522	4,943,096	5,533,789	6,223,838	6,572,775
Equipment Rentals	303,945	492,203	507,552	170,330	175,510	180,848	186,349	973,311	1,002,915	1,033,419	1,052,685
Corporate Services	269,117	236,462	267,181	61,521	110,655	163,701	184,464	389,631	442,213	497,931	525,087
Total Other (D.9)	3,878,534	4,519,743	4,803,389	1,489,285	2,226,050	3,038,953	3,408,581	7,430,843	8,248,654	9,167,925	9,646,053

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Nineteen: Average Charges, Deductions, Net Charges, Net Operating Income 28 Additional Beds		
	CY2014	**CY2015**
Patient **Days**	**4,088**	**6,241**
Admissions or Discharges	143	218
Average Gross Charge **Per Day**	**$4,541**	**$4670**
Average Gross Charge Per Admission	$129,802	$133,696
Average Deduction from Operating Revenue/**Day**	**$3,006**	**$3,123**
Average Deduction from Operating Revenue/Admission	$85,926	$89,395
Average Net Charge (Net Operating Revenue)/**Day**	**$1,535**	**$1547**
Average Net Charge (Net Operating Revenue)/Admission	$43,876	$44,301
Average Net Operating Income after Expenses/**Day**	**$67**	**$82**
Average Net Operating Income after Expenses/Admission	$1,913	$2,354

Table Twenty: Average Charges, Deductions, Net Charges, Net Operating Income 77 Total Beds		
	CY2014	**CY2015**
Patient **Days**	**19,345**	**21,535**
Admissions or Discharges	677	753
Average Gross Charge **Per Day**	**$4,543**	**$4,675**
Average Gross Charge Per Admission	$129,802	$133,696
Average Deduction from Operating Revenue/**Day**	**$3,012**	**$3,127**
Average Deduction from Operating Revenue/Admission	$86,070	$89,418
Average Net Charge (Net Operating Revenue)/**Day**	**$1,530**	**$1,548**
Average Net Charge (Net Operating Revenue)/Admission	$43,732	$44,277
Average Net Operating Income after Expenses/**Day**	**$72**	**$78**
Average Net Operating Income after Expenses/Admission	$2057	$2,220

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

Please see Table Twenty-One on the following page. It shows the gross charge and DRG payment for the most frequent admissions of this hospital.

The renovation project will not have any adverse impact on gross patient charges, which increased approximately 3% from 2010 to 2011, and are projected to increase approximately that amount annually, whether or not the project is implemented.

Table Twenty-One: Charge Data for Most Frequent Types of Admission
Select Specialty Hospital--Memphis

Service: Long Term Hospital Care

DRG	Descriptor	Current Medicare DRG	Average Gross Charge		
			Current	Year 1	Year 2
207	Respiratory system diagnosis w ventilator support 96+ hours	75,187.05	162,337	167,207	172,223
189	Pulmonary Edema & respiratory failure	35,833.94	79,332	81,712	84,163
208	Respiratory system diagnosis w ventilator support <96 hours	41,606.91	69,884	71,981	74,140
539	Osteomyelitis w MCC	40,083.86	78,718	81,080	83,512
592	Skin Ulcers w MCC	33,491.68	74,819	77,064	79,376
949	Aftercare w CC/MCC	27,257.18	52,266	53,834	55,449
981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	81,389.05	230,798	237,722	244,854
4	Trach w MV 96+ hours or PDX exc face, mouth & neck w/o major OR	114,586.31	208,712	214,974	221,423
559	Aftercare, musculoskeletal system & connective tissue w MCC	35,360.87	86,742	89,345	92,025
870	Septicemia or severe sepsis w MV 96+ hours	79,713.89	178,621	183,980	189,499
3	ECMO or trach w MV 96+ hours or PDX exc face, mouth & neck w maj O.R.	159,754.69	377,125	388,439	400,092
314	Other circulatory system diagnosis w MCC	37,095.46	85,573	88,141	90,785
463	WND Debrid & skin graft exc hand, for musculo-conn tissue dis w MCC	55,745.11	181,628	187,077	192,689
871	Septicemia or severe sepsis w/o MV 96+ hours w MCC	33,772.44	65,758	67,730	69,762
638	Diabetes w CC	27,687.94	58,137	59,881	61,678
	All Others	22,454.60	53,581	55,188	56,844

Source: Hospital management

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

The requested Medicare comparison is provided in the table on the preceding page. The table below compares the most recently reported gross charge data for the two operating LTACH's and a third approved LTACH in this service area.

Table Twenty-Two: Comparative Charges Per Patient Day In Shelby County LTACH Facilities 2011 Joint Annual Reports / CN1210-052 (Mem.LT Care Spec'y)

LTACH	Gross Patient Charges	Days	Gross Charge Per Day
Select Specialty CY 2011	$55,365,667	13,469	$4,111
Select Specialty CY 2015	$100,672,847	21,535	$4,675
Baptist Restor. Care CY2011	$44,353,983	8,267	$5,365
Methodist Ext. Care CY2011	$37,557,166	11,337	$3,313
Memph LT Care Spec CY2015	$28,143,153	8,322	$3,382

Source: Joint Annual Reports of Hospitals, 2011; CN1210-052 for Memphis Long Term Care Specialty Hospital; its data is for Year 1 (2015/16. Select Specialty data for 2015 is from this application.

C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

The hospital is already cost-effective and operates with a positive financial margin. Additional census will support continued financial viability.

C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

The hospital operates with a positive financial margin. Additional census will support continued financial viability. Cash flow is not an issue; this is an existing facility with established reimbursement and positive cash flow at all times.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

The hospital in Q1-Q3 2012 had a payor mix of 80.02% Medicare, 3.3% Medicaid, 15.48% Commercial and Workmen's Comp, and 1.3% other. The projections assume that the Medicare and Medicaid payor mix will remain the same though CY2015.

Table Twenty-Three: Select Specialty Hospital-Memphis Medicare and Medicaid Gross Revenue (28-bed P&L) Year One (CY2014)	
Total Gross Revenue	$18,561,633
Medicare Gross Revenue	$14,853,019
% of Gross Revenue	80.02%
Medicaid Gross Revenue	$618,102
% of Gross Revenue	3.33%

Source: Hospital records.

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:

A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.

B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

The alternative of not adding beds at this location was rejected for several reasons. First, the hospital has coped with very high 93% occupancy and routine deferrals of qualified admissions for several years--due to lack of bed space. It is appropriate to respond to this demand without more delay. Second, the availability of beds for conversion, immediately below the existing LTACH floor, offers a feasible opportunity to expand the operation efficiently without relocation or new construction, at a low capital cost. Third, visits to hospitals and physicians in the outlying counties of the service area have convinced hospital management that significant latent additional need for long term acute inpatient care exists there, which Select can meet if it undertakes the approved and proposed bed expansions that will utilize the 11th floor.

The alternative of delaying for the MED's new LTACH to meet market demand was not a reasonable one. The MED's representatives have told the HSDA that the MED's own internal demand for these beds, from patients not now using LTACH beds in the community, is more than enough to completely fill the 24 beds being acquired and moved to the MED campus. That leaves the three existing LTACH's to meet other service area hospitals' needs. Being the most highly utilized of the three, and having no information about the intent or ability of the other two LTACH's to expand as economically at their present locations, Select feels that this proposed expansion is timely and is the best alternative for the service area.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

Select Specialty Hospital is located within the tertiary Saint Francis Hospital. Saint Francis is its "host", in LTACH language. Select contracts with the host hospital and the host's vendors to deliver the ancillary and support services needed by its patients. This includes food and janitorial services, diagnostic imaging and testing, surgery if required, and health professional consults and support on a 24-hour basis. The latter includes all types of physician services that may be needed.

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

Select Specialty Hospital does not project that the project will have any significant or persistent impact on the other existing or approved LTACH providers in this vast 43-county service area.

The preceding response indicated why this project should have no impact on the MED's intended operation of 24 LTACH beds on its campus (they will be completely utilized by MED patients who are not now using LTACH care; and there are sufficient numbers of those patients in the MED to utilize even more beds than the MED has proposed).

With respect to the Baptist and Methodist LTACH's, Select works well with both healthcare systems and believes that their LTACH facilities enjoy high occupancy and a strong positive margin that will not be reduced significantly by Select's provision of beds to meet Select's own demonstrated admissions needs.

There is no way to quantify the impact exactly, but Select believes it would be small, and of short duration. Select anticipates drawing most of its new patients from large hospital providers outside of Memphis, who do not yet have strong referral relationships with hospital systems in Memphis. Currently, eleven hospitals routinely refer patients to Select Specialty Hospital. Management has begun field visits that will result in additional hospitals starting to refer patients routinely to Select in Memphis.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

Table Twenty-Four: TDOL Surveyed Average Salaries for the Region Clinical Professional Positions				
Position	**Entry Level**	**Mean**	**Median**	**Experienced**

Please see the following page for Table Twenty-Five, showing projected FTE's and salary ranges for the project. Current staffing is included.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

Please see the following page for Table Twenty-Five, showing projected FTE's and salary ranges for the project. Current staffing is included.

Table Twenty-Five: Select Specialty Hospital--Memphis
Addition of Licensed Beds
Current and Projected Staffing

Position Type (RN, etc.)	Current FTE's	Year One Projected FTE's	Year Two Projected FTE's	Change, Year Two from Current	Salary Range (Hourly)
Admissions Coordinator	2.0	2.0	2.0	-	$ 16.14
Case Management Secretary	1.0	1.0	1.0	-	$ 13.18
Case Manager	1.0	3.0	3.0	2.0	$ 34.02
Clinical Liaison	4.0	4.0	4.0	-	$ 29.34
C.N.A.	30.6	41.6	46.3	15.7	$ 11.33
HIM Tech	2.0	2.0	2.0	-	$ 14.66
Infection Control	1.0	1.5	1.6	0.6	$ 35.00
LPN	3.0	-	-	(3.0)	$ 20.88
Materials Tech	1.0	1.0	1.5	0.5	$ 17.48
Monitor Tech	4.7	4.7	4.7	-	$ 12.50
Non-Clinical	6.0	6.0	6.0	-	$ 37.51
Occupational Therapy	2.0	3.0	3.0	1.0	$ 45.00
Pharmacist	4.0	4.0	4.0	-	$ 54.28
Pharmacy Tech	1.0	2.4	2.5	1.5	$ 18.15
PT	1.0	2.0	2.0	1.0	$ 40.58
PT Assistant	2.0	2.0	2.0	-	$ 29.01
RN	39.6	56.8	62.9	23.3	$ 32.36
Respiratory Therapist	13.6	18.5	20.6	7.0	$ 22.50
Speech Pathologist	1.0	2.0	2.0	1.0	$ 38.57
Staffing Coordinator	1.0	1.0	1.0	-	$ 11.00
Unit Secretary	4.7	9.4	9.4	4.7	$ 11.53
Wound Care Specialist	2.0	2.0	2.5	0.5	$ 31.66
Total FTE's	128.2	167.9	181.5	55.8	

Source: Hospital Management

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

Select Specialty Hospital-Memphis provides a very attractive work environment and anticipates having no difficulty in staffing the proposed beds. As a licensed facility Select is well aware of, and complies with, State and professional staffing standards and requirements.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

At the time of this application, Select Specialty has no formal contracts under which health professions programs rotate students through the facility for training.

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION

LICENSURE:	Board for Licensure of Healthcare Facilities Tennessee Department of Health
CERTIFICATION:	Medicare Certification from CMS TennCare Certification from TDH
ACCREDITATION:	Joint Commission

C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission on Accreditation of Healthcare Organizations.

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

Not applicable. The applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

March 27, 2013

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	3	4-2013
2. Construction documents approved by TDH	48	5-2013
3. Construction contract signed	53	5-2013
4. Building permit secured	54	5-2013
13	na	na
6. Building construction commenced	67	6-2013
7. Construction 40% complete	123	8-2013
8. Construction 80% complete	183	10-2013
9. Construction 100% complete	203	12-2013
10. * Issuance of license	218	12-2013
11. *Initiation of service	233	1-2014
12. Final architectural certification of payment	293	3-2014
13. Final Project Report Form (HF0055)	323	4-2014

*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

INDEX OF ATTACHMENTS

A.4--Ownership
Legal Entity, Licensure, Accreditation

Board for Licensing Health Care Facilities

State of Tennessee

0000000147

No. of Beds 0039

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

SELECT SPECIALTY HOSPITAL - MEMPHIS, INC. *to conduct and maintain a*

Hospital SELECT SPECIALTY HOSPITAL - MEMPHIS

Located at 5959 PARK AVENUE, 12TH FLOOR, MEMPHIS

County of SHELBY *, Tennessee.*

This license shall expire NOVEMBER 23 *,* 2013 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 1ST *day of* JULY *,* 2012 *.*

In the Distinct Category(ies) of: CHRONIC DISEASE HOSPITAL

By Vincent J. Dario, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner MD

COMMISSIONER

The Joint Commission

May 27, 2010

Jeffery Denney
COO
Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Joint Commission ID #: 148160
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 05/27/2010

Dear Mr. Denney:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning February 19, 2010. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

State of Delaware

Office of the Secretary of State

I, EDWARD J. FREEL, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "SELECT SPECIALTY HOSPITAL - MEMPHIS, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-THIRD DAY OF JUNE, A.D. 1998.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE NOT BEEN ASSESSED TO DATE.

Edward J. Freel, Secretary of State

AUTHENTICATION: 9155356

DATE: 06-23-98

2911675 8300

981241934

State of Delaware

Office of the Secretary of State

I, EDWARD J. FREEL, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF INCORPORATION OF "SELECT SPECIALTY HOSPITAL - MEMPHIS, INC.", FILED IN THIS OFFICE ON THE TWENTY-THIRD DAY OF JUNE, A.D. 1998, AT 10 O'CLOCK A.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE NEW CASTLE COUNTY RECORDER OF DEEDS.

Edward J. Freel, Secretary of State

2911675 8100

981241720

AUTHENTICATION: 9155266

DATE: 06-23-98

CERTIFICATE OF INCORPORATION

OF

SELECT SPECIALTY HOSPITAL - MEMPHIS, INC.

* * * * *

1. The name of the corporation is:

SELECT SPECIALTY HOSPITAL - MEMPHIS, INC.

2. The address of its registered office in the State of Delaware is Corporation Trust Center, 1209 Orange Street, in the City of Wilmington, County of New Castle. The name of its registered agent at such address is The Corporation Trust Company.

3. The nature of the business or purposes to be conducted or promoted is:

To engage in any lawful act or activity for which corporations may be organized under the General Corporation Law of Delaware.

4. The total number of shares of stock which the corporation shall have authority to issue is One Thousand (1,000) and the par value of each of such shares is One Cent ($0.01), amounting in the aggregate of Ten Dollars ($10.00).

5. The name and mailing address of each incorporator is as follows:

NAME	MAILING ADDRESS
Kay L. Mark	c/o Select Medical Corporation 4718 Old Gettysburg Road P. O. Box 2034 Mechanicsburg, PA 17055

6. This corporation is to have perpetual existence.

7. In furtherance and not in limitation of the powers conferred by statute, the board of directors is expressly authorized to make, alter or repeal the by-laws of the corporation.

8. Election of directors need not be by written ballot unless the by-laws of the corporation shall so provide.

Meetings of stockholders may be held within or without the State of Delaware, as the by-laws may provide. The books of the corporation may be kept (subject to any provision contained in the statutes) outside the State of Delaware at such place or places as may be designated from time to time by the board of directors or in the by-laws of the corporation.

9. The corporation reserves the right to amend, alter, change or repeal any provision contained in this Certificate of Incorporation, in the manner now or hereafter prescribed by statute, and all rights conferred upon stockholders herein are granted subject to this reservation.

10. A director of the corporation shall not be personally liable to the corporation or its stockholders for monetary damages for breach of fiduciary duty as a director except for liability (i) for any breach of the director's duty of loyalty to the corporation or its stockholders, (ii) for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law, (iii) under Section 174 of the Delaware General Corporation Law, or (iv) for any transaction from which the director derived any improper personal benefit.

I, THE UNDERSIGNED, being the incorporator hereinbefore named, for the purpose of forming a corporation pursuant to the General Corporation Law of the State of Delaware, do make this Certificate, hereby declaring and certifying that this is my act and deed and the facts herein stated are true, and accordingly have hereunto set my hand this 22nd day of June, 1998.

Kay L. Mark

Kay L. Mark

Secretary of State
Corporations Section
James K. Polk Building, Suite 1800
Nashville, Tennessee 37243-0306

DATE: 06/26/98
REQUEST NUMBER: 3525-1562
TELEPHONE CONTACT: (615) 741-0537
FILE DATE/TIME: 06/26/98 1124
EFFECTIVE DATE/TIME: 06/26/98 1124
CONTROL NUMBER: 0353306

TO:
SELECT SPECIALTYHOSPITAL-MEMPHIS INC
4718 OLD GETTYSBURG
RD
MECHANICSBURG, PA 17055

RE:
SELECT SPECIALTY HOSPITAL - MEMPHIS, INC.
APPLICATION FOR CERTIFICATE OF AUTHORITY -
FOR PROFIT

WELCOME TO THE STATE OF TENNESSEE. THE ATTACHED CERTIFICATE OF AUTHORITY HAS BEEN FILED WITH AN EFFECTIVE DATE AS INDICATED ABOVE.

A CORPORATION ANNUAL REPORT MUST BE FILED WITH THE SECRETARY OF STATE ON OR BEFORE THE FIRST DATE OF THE FOURTH MONTH FOLLOWING THE CLOSE OF THE CORPORATION'S FISCAL YEAR. PLEASE PROVIDE THIS OFFICE WITH WRITTEN NOTIFICATION OF THE CORPORATION'S FISCAL YEAR. THIS OFFICE WILL MAIL THE REPORT DURING THE LAST MONTH OF SAID FISCAL YEAR TO THE CORPORATION AT THE ADDRESS OF ITS PRINCIPAL OFFICE OR TO A MAILING ADDRESS PROVIDED TO THIS OFFICE IN WRITING. FAILURE TO FILE THIS REPORT OR TO MAINTAIN A REGISTERED AGENT AND OFFICE WILL SUBJECT THE CORPORATION TO ADMINISTRATIVE REVOCATION OF ITS CERTIFICATE OF AUTHORITY.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE CORPORATION CONTROL NUMBER GIVEN ABOVE.

FOR: APPLICATION FOR CERTIFICATE OF AUTHORITY - FOR PROFIT

ON DATE: 06/26/98

	FEES	
RECEIVED:	$600.00	$0.00
TOTAL PAYMENT RECEIVED:		$600.00

FROM:
C T CORPORATION SYSTEM (PHILADELPHIA, PA
1635 MARKET STREET
SEVEN PENN CENTER
PHILADELPHIA, PA 19103-0000

RECEIPT NUMBER: 00002331196
ACCOUNT NUMBER: 00000020

Riley C. Darnell

RILEY C. DARNELL
SECRETARY OF STATE

SS-4458

3325 1362

FILED

APPLICATION FOR CERTIFICATE OF AUTHORITY FOR

Select Specialty Hospital - Memphis, Inc.

To the Secretary of State of the State of Tennessee:

98 JUN 26 AM 11:24

Pursuant to the provisions of Section 48-25-103 of the Tennessee Business Corporation Act, the undersigned corporation hereby applies for a certificate of authority to transact business in the State of Tennessee, and for that purpose sets forth:

SECRETARY OF STATE

1. The name of the corporation is Select Specialty Hospital - Memphis, Inc.

If different, the name under which the certificate of authority is to be obtained is N/A

[**NOTE:** The Secretary of State of the State of Tennessee may not issue a certificate of authority to a foreign corporation for profit if its name does not comply with the requirements of Section 48-14-101 of the Tennessee Business Corporation Act. If obtaining a certificate of authority under an assumed corporate name, an application must be filed pursuant to Section 48-14-101(d) and an additional $20.00 fee.]

2. The state or country under whose law it is incorporated is Delaware.

3. The date of its incorporation is June 23, 1998 (must be month, day, and year), and the period of duration, if other than perpetual, is N/A.

4. The complete street address (including zip code) of its principal office is P. O. Box 2034

4718 Old Gettysburg Road	Mechanicsburg	PA	17055
Street	City	State/Country	Zip Code

5. The complete street address (including the county and the zip code) of its registered office in this state is

530 Gay Street	Knoxville, Tennessee	County of Knox	37902
Street	City/State	County	Zip Code

The name of its registered agent at that office is

C T CORPORATION SYSTEM

6. The names and complete business addresses (including zip code) of its current officers are: (Attach separate sheet if necessary.)

See Attached

7. The names and complete business addresses (including zip code) of its current directors are: (Attach separate sheet if necessary.)

See Attached

8. The corporation is a corporation for profit.

9. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date/time is

_____, 19____ (date), _____ (time).

[**NOTE:** A delayed effective date shall not be later than the 90th day after the date this document is filed by the Secretary of State.]

SELECT SPECIALTY HOSPITAL - MEMPHIS, INC.

Rocco A. Ortenzio, Sole Director
c/o Select Medical Corporation
4718 Old Gettysburg Road
P.O. Box 2034
Mechanicsburg, PA 17055

Rocco A. Ortenzio, Chairman & CEO
c/o Select Medical Corporation
4718 Old Gettysburg Road
P. O. Box 2034
Mechanicsburg, PA 17055

Robert A. Ortenzio, President
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Michael E. Tarvin, Vice President
and Secretary
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Scott A. Romberger, Vice President,
Treasurer and Assistant Secretary
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Kenneth L. Moore, Vice President
and Assistant Secretary
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Patricia A. Rice, Vice President
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Stevan B. Baird, Vice President
c/o Select Medical Corporation
4718 Old Gettysburg Road
P. O. Box 2034
Mechanicsburg, PA 17055

STATE OF TENNESSEE

HEALTH FACILITIES COMMISSION

Certificate of Need CN9312-084A is hereby granted under the provisions of T.C.A. §68 11-101, *et seq.*, and the rules and regulations issued thereunder by this Commission

to American Transitional Hospitals of Tennessee, Inc.

for American Transitional Hospital of Middle Tennessee

This Certificate is issued for the establishment of a licensed twenty-five (25) bed hospital in Nashville for the care of acute patients with an average stay of more than twenty-five (25) days conditioned on Centennial Medical Center delicensing thirty-two (32) medical/surgical beds as part of the project and on obtaining Health Care Financing Administration (HCFA) approval for the designation of twenty-five (25) beds as long term care hospital beds

on the premises located at 230 - 25th Avenue North
Nashville (Davidson County), Tennessee 37202-1225

for an estimated project cost of $ 2,158,935.00

The Expiration Date for this Certificate of Need is

June 1, 1997

or upon completion of the action for which the Certificate of Need was granted, whichever occurs first. After the effective date, this Certificate of Need is null and void.

Date Approved April 27, 1994

Date Issued May 31, 1994

Chairman

Secretary

HF-0028 (Rev. 5-93)

STATE OF TENNESSEE

HEALTH FACILITIES COMMISSION

Certificate of Need CN9406-032A is hereby granted under the provisions of T.C.A. §68-11-101, *et seq.*, and the rules and regulations issued thereunder by this Commission

to AMISUB (SFH) d/b/a Saint Francis Hospital

for St. Francis Hospital

This Certificate is issued for the establishment of a thirty (30) bed long-term care hospital; forty-two (42) medical/surgical beds will simultaneously be delicensed.

CONDITION: Approval subject to Health Care Financing Administration (HCFA) certification as a Long Term Care Hospital

on the premises located at 5959 Park Avenue
Memphis, TN 38119-5198

for an estimated project cost of $562,000.00

The Expiration Date for this Certificate of Need is

November 1, 1997

or upon completion of the action for which the Certificate of Need was granted, whichever occurs first. After the effective date, this Certificate of Need is null and void.

Date Approved September 28, 1994

Date Issued October 31, 1994

*Date Reissued: March 6, 1997

* Certificate was reissued to reflect new owner

Oscar Edmonds
Chairman

Linda B Penny
Secretary

HF-0022 (Rev. 5-93)

A.6--Site Control

First Amendment to
Lease Agreement DRAFT 12-12-12

This Amendment (this "Amendment") is made as of December _____, 2012, by and between AMISUB (SFH), Inc. (the "Landlord") and Select Specialty Hospital – Memphis, Inc. (the "Tenant").

WHEREAS Landlord and Tenant are parties to that certain lease dated March 29, 2010 (the "Lease");

WHEREAS Landlord and Tenant have agreed to modify the Lease as set forth herein

NOW THEREFORE, in consideration of the mutual covenants contained herein, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, Landlord and Tenant hereby agree as follows:

1. Incorporation of Recitals; Effectiveness; Conflict. The recitals set forth above, the Lease referred to therein and the exhibits attached hereto are hereby incorporated herein by reference as if set forth in full in the body of this Amendment. Capitalized terms not otherwise defined herein shall have the meanings given to them in the Lease. To the extent of any conflict in the terms of the Lease and this Amendment, this Amendment shall control.

2. Amendment. The Lease is hereby amended as follows:

2.1. Effective as of the Additional Premises Effective Date, as defined herein, the Clinical Premises is amended to add approximately 21,677 square feet of clinical space, located on the 11th floor of the Building, as outlined for descriptive purposes only on Schedule 1-C, attached hereto (the "Additional Premises"), subject to the provisions of this Amendment. The "Additional Premises Effective Date" shall be the date upon which Tenant admits its first patient in the Additional Premises. Landlord shall give Tenant access to the Additional Premises prior to the Additional Premises Effective Date as necessary to permit Tenant to prepare the Additional Premises for Tenant's use.

2.2. Tenant shall have the right to terminate its lease of the Additional Premises by written notice to Landlord given at any time prior to the Additional Premises Effective Date if Tenant is unable to increase the number of beds operated by Tenant in the Clinical Premises.

2.3. The Term of the Lease is hereby extended for a period of five (5) years, from the date hereof (the "First Extended Term"). Tenant shall have the right to further extend the Term for an additional five (5) years (the "Second Extended Term"), by written notice given to Landlord not less than one hundred twenty (120) days prior to the expiration of the First Extended Term.

2.4. The rent for the Clinical Premises, as modified in this Amendment, shall be based upon the number of beds licensed by Tenant in the Clinical Premises, consistent with Section 4 of the Lease.

2.5. Landlord will de-license a number of beds equal to the number of beds by which Tenant increases the total number of beds in Tenant's hospital, up to a maximum of 38 beds.

3. Survival. All other terms and conditions contained in the Lease will remain in full force and effect, except as specifically modified herein.

[Signature Page Follows]

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto have caused this Amendment to be executed by their duly authorized representatives.

LANDLORD	TENANT
AMISUB (SFH), Inc.	SELECT SPECIALTY HOSPITAL – MEMPHIS, INC.
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

SCHEDULE 1-C

The Additional Premises

LEASE AGREEMENT

THIS LEASE AGREEMENT (the "Lease") is made and entered into as of March 29, 2010 (the "Effective Date") between AMISUB (SFH), Inc., a Tennessee corporation, doing business as Saint Francis Hospital ("Landlord") and Select Specialty Hospital – Memphis, Inc. ("Tenant").

WHEREAS, Landlord is the possessor of the use of that certain building known as the Saint Francis Hospital ("Building"), located at 5959 Park Avenue, in the City of Memphis, Shelby County, Tennessee; and

WHEREAS, Tenant desires to enter into a lease for certain clinical space and certain office space in said Building.

NOW, THEREFORE, Landlord hereby leases to Tenant, and Tenant hereby leases from Landlord, a portion of the Building upon the following terms and conditions:

1. **LEASED PREMISES.** The portion of the Building leased to Tenant by Landlord shall consist of (a) approximately 21,677 square feet of clinical space, located on the 12th floor of the Building, as outlined for descriptive purposes only on Schedule 1-A, attached hereto (hereinafter referred to as the "Clinical Premises") and (b) approximately 598.5 square feet of administrative office space, located on 1st floor, as outlined for descriptive purposes only on Schedule 1-B, attached hereto (hereinafter referred to as the "Administrative Office Premises"). The Clinical Premises and the Administrative Office Premises are collectively referred to as the "Premises". Landlord and Tenant hereby acknowledge and agree that the Premises (a) do not exceed that which is commercially reasonable and necessary for the legitimate business purposes of this Lease; (b) are used exclusively by Tenant on a full-time basis during the Term (as defined in Section 3 below); and (c) except for the existing lease of administrative office space between Landlord or its affiliate and Tenant, represent all of the premises leased between Landlord and Tenant during the Term.

2. **PARKING AND COMMON AREAS.** In addition to the Premises hereinabove described, Tenant shall have nonexclusive use of the parking area(s) appurtenant to the Building and common areas, including corridors, lobbies, elevators, and rest rooms, for Tenant and Tenant's employees, clients and patrons, subject to such reasonable rules and regulations which may from time to time be adopted by Landlord or an authorized authority. Additional Landlord Rules and Regulations are attached hereto as Exhibit A and incorporated herein by this reference. Use of the parking and common areas shall be included in the base rent set forth in Section 4.a hereof.

3. **TERM.**

a. The term of this Lease ("Term") shall be for a period of three (3) years. At the end of the Initial Term, this Lease may be extended for two additional one (1) year terms ("Term Extension") upon the mutual agreement of the parties. As used herein "Term" shall mean the period of time beginning on the Effective date and ending on the last day of either the Initial Term or the last Term Extension, as applicable.

b. Should Tenant hold over and remain in possession of the Premises after the expiration of this Lease, then during such tenancy, monthly rent shall be payable in an amount equal to the rent paid for the last month of the term hereof plus fifteen percent (15%) of the monthly base rental amount. All other terms and conditions of this Lease shall continue in full force and effect during such hold-over tenancy. Notwithstanding the foregoing, Landlord may use all reasonable and appropriate legal remedies to cause Tenant to vacate the Premises.

c. Tenant shall vacate the Premises in the same good condition and repair as received on the Effective Date, ordinary wear and tear and damage from casualty excepted provided Tenant is not in default under the terms hereof, Tenant shall remove from the Premises all Tenant's personal property in order that Landlord can repossess the Premises on the day this Lease or any extension hereof expires or is sooner terminated. Notwithstanding the foregoing, Tenant shall not be required to remove any alterations, improvements or changes approved by Landlord pursuant to Section 12. Any removal of Tenant's property by Tenant shall be accomplished in a manner that will minimize any damage or injury to the Premises, and any such damage or injury shall be forthwith repaired by Tenant at its/his/her sole cost and expense.

4. **RENT.**

a. Tenant shall pay to Landlord as base rent for the Clinical Premises, without notice or demand and without abatement deduction or setoff, except as elsewhere provided herein, the annual amount of Five Hundred Eighty Five Thousand and 00/100 Dollars ($585,000.00), or $15,000.00 per licensed bed (39 Beds x $15,000.00 = $585,000.00). Said base rent shall be paid in advance in equal monthly installments of Forty Eight Thousand Seven Hundred Fifty and 00/100 Dollars ($48,750.00), on the first day of each and every calendar month during the term of this Lease; provided, however, that in the event the term hereof commences on a day other than the first day of a calendar month, then upon the Effective Date hereof Tenant shall pay to Landlord a pro-rata portion of rent to that portion of the calendar month remaining from the Effective Date to the first day of the next following calendar month.

b. Tenant shall pay to Landlord as base rent for the Administrative Office Premises, without notice or demand and without abatement deduction or setoff, except as elsewhere provided herein, the annual amount of Thirteen Thousand One Hundred Sixty Seven and 00/100 Dollars ($13,167.00), or $22.00 per square foot of the Administrative Office Premises. Said base rent shall be paid in advance in equal monthly installments of One Thousand Ninety Seven and 25/100 Dollars ($1,097.25), on the first day of each and every calendar month during the term of this Lease; provided, however, that in the event the term hereof commences on a day other than the first day of a calendar month, then upon the Effective Date hereof Tenant shall pay to Landlord a pro-rata portion of rent to that portion of the calendar month remaining from the Effective Date to the first day of the next following calendar month.

c. The base rent for both the Clinical Premises and the Administrative Office Premises as set forth above shall be increased annually, commencing with the date twelve months after the Effective Date of the term (the "Adjustment Date"), by the increase, if any, of the Consumer Price Index for U.S. Cities – "Urban Wage Earners and Clerical Workers," "All

Items" ("Index"), as published by the United States Department of Labor Bureau of Labor Statistics, over the "Base Period Index", CPI shall be capped at 3%. The "Base Period Index" shall be the index for the calendar month immediately preceding the Effective Date. The Base Period Index shall be compared with the Index for the same calendar month for the subsequent year ("Comparison Index"). If the Comparison Index is higher than the Base Period Index, then the base rent shall be increased by the identical percentage commencing on the Adjustment Date. Notwithstanding the foregoing, in no event shall the adjusted rent be less than the rent in effect immediately prior to the adjustment. When the adjusted rent for the Adjustment Date has been determined, Landlord shall give Tenant written notice of such adjusted rent; and, upon adjustment of the rent, any underpayment of rent from the Adjustment Date to the date Tenant is notified of the adjustment shall be due and payable by Tenant within thirty (30) days after Tenant is so notified. Landlord's failure or delay to notify Tenant of said rent adjustment shall not constitute a waiver of the right to any adjustment provided for in this Lease. In the event that the Index shall be discontinued, then Landlord shall use an index substantially similar to the Index to calculate future adjustments.

d. No payment by Tenant or receipt by Landlord of a lesser amount than the monthly payment in this Lease shall be considered anything other than a payment on account of the earliest rent due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as rent be deemed in accord and satisfaction. Landlord may accept such payment without prejudice to its right to recover the balance of the rent and to pursue any other remedy provided for in this Lease, or otherwise available at law or in equity.

e. All payments under this Lease to be made by Tenant to Landlord shall be made payable to, and mailed or personally delivered to, Landlord at the following address, or such other place as may be designated in writing by Landlord:

Saint Francis Hospital
P.O. Box 845610
Dallas, Texas 75284-5610

f. If any installment of base rent is not paid on the first of the month in which such installment is due, it shall bear interest at the rate of ten percent (10%) per annum until paid, and in addition the rental payment shall be subject to a twenty-five dollar ($25.00) late service charge per month if not paid on or before the tenth (10th) day of each month. However, this provision shall not relieve Tenant from any default.

g. If applicable in the jurisdiction where the Premises are situated, Tenant shall pay and be liable for all rental, sales and use taxes or other similar taxes, if any, levied or imposed by any city, state, county or other governmental body having authority, such payments to be in addition to all other payments required to be paid to Landlord by Tenant under the terms of this Lease. Any such payment shall be paid concurrently with the payment of the rent upon which such tax is based.

5. **ADDITIONAL RENT.** All taxes, charges, costs, and expenses that Tenant assumes or agrees to pay hereunder, together with all interest and penalties that may accrue thereon in the event of failure of Tenant to pay those items and all other damages, costs, expenses, and sums

that Landlord may suffer or incur, or that may become due, by reason of any default of Tenant or failure by Tenant to comply with the terms and conditions of this Lease shall be deemed to be additional rent; and, in the event of nonpayment, Landlord shall have all rights and remedies as herein provided for failure to pay rent.

6. **REASONABLE RENT.** Landlord and Tenant hereby acknowledge and agree that the rental payments required pursuant to this Lease are the product of bona fide, arms-length negotiations and represent the commercially reasonable, fair market value of the Premises for general commercial purposes, without taking into account the intended use of the Premises or the volume or value of any actual or expected federal health care program or other referrals to, or business otherwise generated for, either Landlord or Tenant. The rental payments do not reflect any additional value Landlord or Tenant may attribute to the proximity or convenience of the Premises to sources of referrals or business otherwise generated for which payment may be made in whole or in part under any federal health care program.

7. **INTENTIONALLY OMITTED.**

8. **USE OF PREMISES.**

a. Tenant shall use and occupy the Premises throughout the term of the Lease solely for (1) the purpose of operating and maintaining a program of services within a duly licensed hospital having approximately thirty nine (39) beds contained within Facility which will occupy Premises to provide long term (average length of stay of 25 Days) acute care services. The program of services provided by Tenant shall consist of the following patient services: long term, acute medically complex patient services, pulmonary/ventilation rehabilitation services, long term Pediatric rehabilitation services, neuro spinal cord rehabilitation services, long term oncology treatment services, subacute rehabilitation services, and related office use and such services as are ancillary to or reasonably necessary for the development, management, and operation of the foregoing patient service categories. Anything herein contrary notwithstanding, however, Tenant shall provide services hereunder only to patients which, in the aggregate, shall have an annualized average length of stay of greater than twenty-five (25) days and thereby Tenant shall achieve Medicare designation for the hospital to be operated and managed by Tenant as a long term care hospital; and (2) related office use and such uses as are ancillary to or necessary for the development, operation and management of the program of services provided by Tenant, and for no other purpose without the prior written consent of Landlord which consent shall not be unreasonably withheld. Tenant shall administer its services with a level of care generally accepted in the medical community, and shall assure that all services provided within the Premises meet any and all applicable standards, licensure requirements, ruling and regulations of the State Board of Health and those of all other federal, state or local government agencies exercising authority with respect to Tenant's services.

b. Tenant shall comply with all laws, ordinances, rules, regulations and codes of all municipal, county, state and federal authorities pertaining to the use and occupation of the Premises. No use shall be made or permitted to be made of the Premises, nor acts done, which will increase the existing rate of insurance upon the Building in which said Premises may be located, or cause a cancellation of any insurance policy covering said Building, or any part thereof, nor shall Tenant sell, or permit to be kept, used, or sold, in or about said Premises, any

article which may be prohibited by the standard form of fire insurance policies. Tenant shall not commit, or suffer to be committed, any waste upon said Premises or any public or private nuisance, or other act or thing which may disturb the quiet enjoyment of any other tenant in the Building in which the Premises may be located. Without limiting the generality of the foregoing, Tenant shall not allow said Premises to be used for: (i) any improper, immoral, unlawful or objectionable purpose, (ii) the keeping, storing or selling of intoxicating liquors, or (iii) except in connection with the normal operation of Tenant's hospital, any kind of eating house, sleeping purposes, for washing clothes, or cooking therein. Nothing shall be prepared, manufactured or mixed in said Premises which might emit an odor in the corridors of said Building, nor shall Tenant use any apparatus, machinery or devises in or about the Premises which shall make any noise or set up any vibration or which shall in any way increase the amount of electricity, water or compressed air agreed to be furnished or supplied under this Lease (if any), and Tenant further agrees not to connect with electric wires, water or air pipes any apparatus, machinery or device without the consent of Landlord not to be unreasonably withheld, conditioned or delayed.

9. ENVIRONMENTAL COMPLIANCE/HAZARDOUS MATERIALS.

a. **Definitions.** "Hazardous Materials" shall mean any material, substance or waste that is or has the characteristic of being hazardous, toxic, ignitable, reactive or corrosive, including, without limitation, petroleum, PCBs, asbestos, materials known to cause cancer or reproductive problems and those materials, substances and/or wastes, (excluding infectious waste, medical waste, and potentially infectious biomedical waste), which are or later become regulated by any local governmental authority, the state in which the Premises are located or the United States Government, including, but not limited to, substances defined as "hazardous substances," "hazardous materials," "toxic substances" or "hazardous wastes" in the Comprehensive Environmental Response, Compensation and Liability § 9601, et seq.; the Hazardous Materials'Act of 1980, as amended, 42 U.S.C. § 1801, et seq.; the Resource Conservation and'Transportation Act, 49 U.S.C. Recovery Act, and any law, ordinance or regulation dealing with underground storage tanks; and in the regulations adopted, published and/or promulgated pursuant to said laws, and in any other environmental law, regulation or ordinance now existing or hereinafter enacted, including without limitation those relating to biomedical and infectious waste (collectively, "Hazardous Materials Laws").

b. **Landlord's Representations and Warranties re: Condition of Premises at Commencement of Lease.** Landlord hereby represents and warrants to Tenant as follows, which representations are made as of the date of execution of the Lease and as of the Lease Effective Date:

(1) **No Violation of Hazardous Materials Laws.** Landlord has not generated, manufactured, refined, transported, treated, stored, handled, disposed of, transferred, produced or processed any Hazardous Materials on the Premises, except in full compliance with all Hazardous Materials Laws, and Landlord has no knowledge of any ongoing release of Hazardous Materials on, under or about the Premises.

(2) **No Notices, Litigation or Liens.** Landlord has not received any written request for information, notice, demand letter, administrative inquiry or formal or informal complaint or claim from or by any public or private agency or entity concerning any

release or discharge of any Hazardous Materials on, under, about or off of the Premises or any alleged violation of any Hazardous Materials Laws involving the Premises or any property in the vicinity of the Premises. No litigation is pending or, to the actual knowledge of Landlord without investigation, expressly threatened in writing with respect to the Premises concerning any Hazardous Materials or any Hazardous Materials Laws. No lien has been imposed or, to the actual knowledge of Landlord without investigation, threatened to be imposed against the Premises by any governmental agency or entity in connection with the presence of Hazardous Materials or violation of any Hazardous Materials laws on or off of the Premises.

(3) **Radon Gas.** Tenant acknowledges that radon is a naturally occurring radioactive gas that, when it has accumulated in a building in sufficient quantities, may present health risks to persons who are exposed to it over time. Tenant further acknowledges that levels of radon that exceed federal and state guidelines have been found in buildings in the state in which the Premises are located and that additional information regarding radon and radon testing may be obtained from your county public health unit.

c. **Use of Premises by Tenant; Remediation of Contamination Caused By Tenant.**

(1) **Use.** Tenant hereby agrees that Tenant and Tenant's officers, directors, employees, representatives, agents, contractors, subcontractors, successors, assigns, sublessees, concessionaires, invitees and any other occupants of the Premises (for purposes of this Section, referred to collectively herein as "Tenant Representatives") shall not use, generate, manufacture, refine, produce, process, store or dispose of, on, under or about the Premises or transport to or from the Premises any Hazardous Materials, except in compliance with applicable Hazardous Materials Laws. Furthermore, Tenant shall at its/his/her own expense procure, maintain, and comply with all conditions of, any and all permits, licenses and other governmental and regulatory approvals required for the storage, use or disposal by Tenant or any of Tenant's Representatives of Hazardous Materials on the Premises, including without limitation, discharge of (appropriately treated) materials or wastes into or through any sanitary sewer serving the Premises.

(2) **Remediation.** If at any time during the term, any contamination of the Premises by Hazardous Materials shall occur where such contamination is caused by the act or omission of Tenant or Tenant's Representatives ("Tenant Contamination"), then Tenant, at Tenant's sole cost and expense, shall promptly and diligently remove such Hazardous Materials from the Premises or the property or the groundwater underlying the Premises in accordance with the requirements of the applicable Hazardous Materials Laws and industry standards then prevailing in the Hazardous Materials management and remediation industry in the state in which the Premises are located. Tenant shall not take any required remedial action in response to any Tenant's Contamination in or about the Premises or enter into any settlement agreement, consent, decree or other compromise in respect to any claims relating to any Tenant's Contamination without first notifying Landlord of Tenant's intention to do so and affording Landlord the opportunity to appear, intervene or otherwise appropriately assert and protect Landlord's interest with respect thereto. In addition to all other rights and remedies of Landlord hereunder, if Tenant does not promptly and diligently take all steps to prepare and obtain all necessary approvals of a remediation plan for any Tenant's Contamination, and thereafter

commence the required remediation of any Hazardous Materials released or discharged in connection with Tenant's Contamination within thirty (30) days after Landlord has reasonably approved Tenant's remediation plan and all necessary approvals and consents have been obtained and thereafter continue to prosecute said remediation to completion in accordance with the approved remediation plan, then Landlord, at its sole discretion, shall have the right, but not the obligation, to cause said remediation to be accomplished, and Tenant shall reimburse Landlord within fifteen (15) business days of Landlord's demand for reimbursement of all amounts reasonably paid by Landlord (together with interest on said amounts at the lower of (a) 18% or (b) the highest lawful rate until paid), when said demand is accompanied by proof of payment by Landlord of the amounts demanded. Tenant shall promptly deliver to Landlord copies of hazardous waste manifests reflecting the legal and proper disposal of all Hazardous Materials removed from the Premises as part of Tenant's remediation of any Tenant's Contamination.

(3) **Disposition of Hazardous Materials**. Except as discharged into the sanitary sewer or otherwise removed from the Premises in strict accordance and conformity with all applicable Hazardous Materials Laws, Tenant shall cause any and all Hazardous Materials removed from the Premises as part of the required remediation of Tenant's Contamination to be removed and transported solely by duly licensed haulers to duly licensed facilities for final disposal of such materials and wastes.

d. **Notice of Hazardous Materials Matters.** Each party hereto (for purposes of this Section, "Notifying Party") shall immediately notify the other party (for purposes of this Section, "Notice Recipient") in writing of: (i) any enforcement, clean-up, removal or other governmental or regulatory action instituted, contemplated or expressly threatened in writing concerning the Premises pursuant to any Hazardous Materials Laws; (ii) any claim made or threatened by any person against the Notifying Party or the Premises relating to damage contribution, cost recovery, compensation, loss or injury resulting from or claimed to result from any Hazardous Materials on or about the Premises; and (iii) any reports made to any environmental agency arising out of or in connection with any Hazardous Materials in or removed from the Premises including any complaints, notices, warnings or asserted violations in connection therewith, all upon receipt by the Notifying Party of actual knowledge of any of the foregoing matters. Notifying Party shall also supply to Notice Recipient as promptly as possible, and in any event within five (5) business days after Notifying Party first receives or sends the same, with copies of all claims, reports, complaints, notices, warnings or asserted violations relating in any way to the Premises or Tenant's use thereof.

10. UTILITIES AND SERVICES.

a. Landlord agrees to furnish the Premises with heat and air conditioning twenty-four hours a day, seven days per week. Landlord shall furnish elevator services, if installed, water (including hot water) and electric current for lighting and ordinary medical equipment and business appliances, such as electric system, and telephone service. Landlord shall maintain and repair the plumbing within the Premises, except where a repair to same is needed as a result of Tenant's, its/his/her employees' or invitees' negligence or misuse, and Tenant agrees to pay for all other services supplied to said Premises not enumerated in this Section. Tenant shall be responsible for the payment of the cost of installing any such additional

trunk lines, chips or other apparatus that are necessary for the telephone service required by Tenant. Landlord shall be responsible for the removal of Tenant's trash, provided same be requested by Tenant, but said trash shall be placed by Tenant in its/his/her containers which shall be located within Tenant's Premises. Landlord shall maintain: (1) in good order and repair and in a clean and orderly condition the Building, together with any parking area owned by Landlord which is adjacent to the Building and (2) in good order and repair the Premises; provided, that: (A) Tenant shall be responsible for housekeeping services in the Premises and (B) if repairs to the non-structural elements of the Premises are required because of the negligence or willful misconduct of Tenant, Tenant shall reimburse Landlord for the reasonable costs of such repairs. Landlord, however, shall not be liable for failure to furnish any of the foregoing when such failure is caused by conditions beyond the control of Landlord, or by accidents, repairs or strikes, nor shall such failure constitute an eviction; nor shall Landlord be liable under any circumstances for loss of or injury to property, however occurring, through or in connection with or incidental to the furnishing of any of the foregoing.

b. Notwithstanding any of the provisions of this Section, Tenant shall be responsible for the lawful removal and cost of removing infectious waste from the Premises.

11. **TAXES AND ASSESSMENTS.** Landlord covenants and agrees to pay promptly when due all real property taxes assessed against the Premises and all personal property taxes assessed by any governmental authority upon the property of Landlord in, upon or about the Premises. Tenant covenants and agrees to pay promptly when due all personal property taxes levied and assessed by any governmental authority upon the property of Tenant in, upon or about the Premises.

12. **ALTERATION OF PREMISES.** Tenant shall not alter, repair or change the Premises without the prior written consent of Landlord, which consent shall not be unreasonably withheld. Unless otherwise provided by written agreement, all alterations, improvements, and changes that may be required shall be done either by or under the direction of Landlord, but at the expense of Tenant. Such alterations, improvements, and changes shall remain a part of and be surrendered with the Premises unless Landlord directs, in writing at least 90 days prior to the termination of the Lease term, that the Premises to be restored to the original condition. Such restoration shall be accomplished on or before the expiration of this Lease at the expense of Tenant.

13. **HOSPITAL AND PATIENT RECORDS.**

a. All medical charts and records of the patients and patient care with respect to patients for whom Tenant provides services hereunder shall be the property of Tenant and, except as otherwise provided herein, shall be kept by Tenant upon termination or expiration of this Lease. In the event that Tenant is in default and this Lease terminates pursuant to the terms hereof, Tenant shall cooperate with Landlord in transferring patient records for any patients which may be then housed in the Facility in accordance with all applicable health care statutes, laws, rules, regulations and good and sound medical practice and Tenant shall, at all times, comply with such rules regarding transfer of ownership and/or operation in all respects.

b. Landlord and Tenant agree that they shall retain and make available upon request for a period of four (4) years after the furnishing or services under this Lease, this Lease

and all books, documents, and records which are necessary to certify the cost thereof when requested by the Secretary of Health and Human Services or the Comptroller General, or any of their duly authorized representatives. Landlord and Tenant further agree that if any of either respective duties under this Lease are carried out through a subcontractor, Landlord or Tenant, whichever one is applicable, shall obtain the written commitment from such subcontractor that such subcontractor shall retain and make the subcontractor and all documents, books and records available on the same basis and to the same extent. This provision relating to the above retention and production of documents is included because of possible application of Section 1862(v)(I) of the Social Security Act to this Lease. If the foregoing provision should be found to be inapplicable, then this paragraph shall be deemed to be inoperative and without force or effect.

14. **SIGNS:** Tenant, at Tenant's sole cost and expense, may place and maintain in and about the Facility and the Premises neat and appropriate signs, advertisements or notices clearly identifying Tenant and its business therein as separate and distinct from the Facility, subject to Landlord's general signage policies and programs as respects the Facility. Upon the expiration or earlier termination of this Lease, Tenant shall remove all signs and repair any damage to the Premises or the Facility caused by the erection, maintenance or removal of the signs.

15. **ANCILLARY AND OTHER SERVICES:** During the Term of this Lease, Landlord shall make available and provide to Tenant ancillary and other services offered by Landlord at the Facility in the manner, and for the prices, and upon such terms and conditions as set forth in a Purchased Services Agreement executed by and between the parties contemporaneously with the execution of this Lease.

16. **INSURANCE.**

a. During the Term of this Lease, Landlord shall secure and maintain a general liability policy with such coverage and at such limits as Landlord shall deem appropriate. Landlord shall also maintain policies of insurance insuring the Building and its contents (other than Tenant's property as set out in the sections below) against loss or damage by fire or other casualty, with extended coverage. Tenant shall not be named as an insured party in the policies, and Tenant shall have no right to any part of the proceeds thereof.

b. Tenant shall secure and maintain at all times during the Term, at Tenant's sole expense, commercial general liability insurance covering Tenant, and all of Tenant's employees, with a carrier licensed to do business in the State and having at least an "A" A.M. BEST rating, at the following limits:

Commercial General Liability covering bodily injury and property damage to third parties and including Products/Completed Operations, Blanket Contractual Liability, Personal/Advertising Injury, Fire Legal, and Medical Payments:

$1,000,000 per occurrence; $3,000,000 general aggregate;
$1,000,000 per occurrence Personal/Advertising Injury;
$1,000,000 Products/Completed Operations aggregate;
$100,000 Fire Legal Liability;
$5,000 Medical Payments

This coverage can be provided in a manner that is normal and customary for the Tenant's business and may be structured under a single policy or combination or policies with total Aggregate Limits of Liability not less than $3,000,000. Tenant shall, at Landlord's request, provide a Certificate of Insurance evidencing this coverage and any applicable deductibles or self-insured retentions. Such insurance shall name Landlord and Landlord's mortgagee as additional insureds and shall not be cancelable except upon 30 days' prior written notice to Landlord. Such coverage shall be primary and non-contributory. Tenant shall annually provide Landlord a certificate of insurance evidencing such coverage and coverage extensions.

c. Tenant shall also secure and maintain at all times during the Term, at Tenant's sole expense, workers' compensation and employers' liability insurance covering Tenant's employees, with a carrier licensed to do business in the State and having at least an "A" BEST rating, at the following limits:

Workers' Compensation:	Statutory limits
Employers' Liability:	$1,000,000 each accident;
	$1,000,000 disease policy limit;
	$1,000,000 disease each employee

Such coverage shall be placed as an actual Workers' Compensation policy, not as a health benefits policy, and shall be endorsed to include (1) a waiver of subrogation in favor of Landlord, and (2) a 30-day notice of cancellation. Such coverage shall be primary and non-contributory. Tenant shall annually provide a certificate of insurance to Landlord evidencing such coverage and coverage extensions.

d. Tenant shall secure and maintain at all times during the Term, at Tenant's sole expense, professional liability insurance covering Tenant, and all of Tenant's healthcare professional employees, with a carrier licensed to do business in the State and having at least an "A" A.M. BEST rating, at the following limits:

$1,000,000 per claim/occurrence and $3,000,000 aggregate

This coverage can be provided in a manner that is normal and customary for the Tenant's business and may be structured under a single policy or combination of policies with Total Aggregate Limits of Liability not less than $3,000,000. Tenant shall, at Landlord's request, provide a Certificate of Insurance evidencing this coverage and any applicable deductible or self-insured retentions. Such coverage shall be primary and non-contributory. Tenant shall annually provide Landlord a certificate of insurance evidencing such coverage and coverage extensions. This coverage shall be either (1) on an occurrence basis or (2) on a claims-made basis. If the coverage is on a claims-made basis, Tenant hereby agrees that prior to the effective date of termination of Tenant's current insurance coverage, Tenant shall purchase, at Tenant's sole expense, either a replacement policy annually thereafter having a retroactive date no later than the Effective Date or tail coverage in the above stated amounts for all claims arising out of incidents occurring prior to termination of Tenant's current coverage or prior to termination of

this Lease, and Tenant shall provide Landlord a certificate of insurance evidencing such coverage.

e. Tenant shall secure and maintain at all times when Tenant is performing Alterations to the Premises, at Tenant's sole expense, builders' risk coverage for the full construction cost of the project on a replacement cost basis, and a bid bond and subsequently a performance bond for the intended work for 100% of the value of the work. Such insurance shall name Landlord (or, at Landlord's request, Landlord's mortgagee) as a Loss Payee.

f. Tenant shall secure and maintain at all times during the Term, at Tenant's sole expense, special causes of loss, property insurance covering tenant improvements and betterments and Tenant's personal property. Valuation shall be at replacement cost. Landlord (or, at Landlord's request, Landlord's mortgagee) shall be named as Loss Payee under Tenant's insurance coverage for tenant improvements and betterments.

g. Anything in this lease to the contrary notwithstanding, Landlord and Tenant each hereby waives any and all rights of recovery, claim, action or cause of action, against the other, their respective affiliates, or the agents, servants, partners, members, shareholders, officers or employees thereof, for any loss or damage that may occur to the leased premises, the associated project, or any improvements thereto or thereon, or any property of such party therein or thereon, by reason of fire, the elements, or any other cause that is, or is required to be, insured against under the terms of this Lease. THE FOREGOING WAIVERS SHALL APPLY REGARDLESS OF THE AMOUNT OF THE PROCEEDS PAYABLE UNDER SUCH INSURANCE POLICIES AND THE CAUSE OR ORIGIN OF THE LOSS, INCLUDING THE NEGLIGENCE OF THE OTHER PARTY HERETO, THEIR RESPECTIVE AFFILIATES, OR THE AGENTS, OFFICERS, PARTNERS, MEMBERS, SHAREHOLDERS, SERVANTS OR EMPLOYEES THEREOF. Landlord and Tenant each covenant and agree that no insurer shall hold any right of subrogation or assignment of any claim against such other party, regardless of whether such claim relates to an insured loss or otherwise. Landlord and Tenant shall advise insurers of the foregoing waiver and such waiver shall be a part of each policy maintained by Landlord and Tenant.

17. INDEMNIFICATION OF LANDLORD.

a. Tenant, as a material part of the consideration to be rendered to Landlord under this Lease, hereby waives all claims against Landlord for damages to goods, wares, and merchandise in and about said Premises and for injuries to persons in or about said Premises from any cause beyond Landlord's control. Tenant shall indemnify, protect, defend, and hold Landlord harmless from and against any and all claims, liabilities, losses, damages, and suits arising from Tenant's use, occupancy or enjoyment of the Premises and its facilities or the conduct of Tenant's business or from any activity, work or things done, permitted or suffered by Tenant, or its/his/her agents and employees in or about the Premises, and Tenant further agrees to indemnify, protect, defend, and hold Landlord harmless from and against any and all claims arising from any breach or default in the performance of any obligation on Tenant's part to be performed under the terms of this Lease or arising from any negligence of Tenant, or any of its/his/her agents, contractors, employees, invitees or licensees, and from and against all costs,

attorneys' fees, expenses, and liabilities of any kind incurred in or about any such claim or any action or proceeding brought thereon; and in case any action or proceeding be brought against Landlord by reason of any such claim, Tenant, upon notice from Landlord, shall defend the same at Tenant's sole cost and expense by counsel reasonably satisfactory to Landlord. Landlord shall not be liable to Tenant for any damage resulting from the negligence of any co-tenant or other occupant of the same Building or by any owner or occupant of adjoining or contiguous property. Tenant agrees to pay for all damages to the Building as well as all damage to the tenants or occupants thereof caused by Tenant's negligence, misuse, or neglect of said Premises, its apparatus or appurtenances.

b. Landlord shall indemnify, protect, defend, and hold Tenant harmless from and against any and all claims, liabilities, losses, damages, and suits arising from Landlord's use, occupancy or enjoyment of the building and its facilities or the conduct of Landlord's business or from any activity, work or things done, permitted or suffered by Landlord, or its/his/her agents and employees in or about the common areas and the building, and Landlord further agrees to indemnify, protect, defend, and hold Tenant harmless from and against any and all claims arising from any breach or default in the performance of any obligation on Landlord's part to be performed under the terms of this Lease or arising from any gross negligence of Landlord, or any of its/his/her agents, contractors, employees, invitees or licensees, and from and against all costs, attorneys' fees, expenses, and liabilities of any kind incurred in or about any such claim or any action or proceeding brought thereon; and in case any action or proceeding be brought against Tenant by reason of any such claim, Landlord, upon notice from Tenant, shall defend the same at Tenant's sole cost and expense by counsel reasonably satisfactory to Landlord. Landlord agrees to pay for all damages to the Building as well as all damage to Tenant caused by Landlord's gross negligence, misuse, or neglect of said Building, its apparatus or appurtenances.

18. **MECHANIC'S LIENS.** Tenant shall not suffer nor permit any mechanic's liens or materialman's liens to be filed against the real property of which the Premises form a part nor against Tenant's leasehold interest in the Premises.

a. Landlord shall have the right at all reasonable times to post and keep posted on the Premises any notices which it deems necessary for protection from such liens. If such liens are so filed and not released within 30 days, Landlord, at its election, may pay and satisfy same and, in such event the sums so paid by Landlord, plus all related actual and other expenses, including attorney's fees, shall accrue interest at the rate of ten percent (10%) per annum from the date of payment and shall be deemed to be additional rent immediately due and payable by Tenant without notice or demand.

19. **ABANDONMENT OF PREMISES.** Tenant shall not vacate or abandon the Premises for a period of greater than ninety (90) days without paying base rent at any time during the term of this Lease; and if Tenant shall do so, any personal property belonging to Tenant left in the Premises shall be deemed abandoned, at the option of Landlord.

20. **LANDLORD'S RIGHT OF ENTRY.** Landlord or its agents shall have the right to enter the Premises at reasonable times upon reasonable advance notice to Tenant in order to examine it, to show it to prospective tenants, lenders, ground lessors, and purchasers, or to make such decorations, repairs, alterations, improvements or additions as Landlord shall deem

necessary or desirable. Landlord will give Tenant reasonable notice of its requirements, and will be responsible for conducting such work so as not to unreasonably impair Tenant's use and enjoyment of the Premises and to comply with all patient privacy laws and regulations as set forth in the Health Insurance Portability and Accountability Act of 1966 (HIPAA) Privacy Rule, as amended ("HIPAA"). Landlord shall be allowed to take all material into and upon the Premises that may be required therefor without the same constituting an eviction of Tenant in whole or in part. Tenant's rent shall be abated while decorations, repairs, alterations, improvements or additions are being made by Landlord only when there is a loss or interruption of the business of Tenant and only when such an abatement is warranted by the circumstances. The granting of such an abatement must be approved in writing by Landlord prior to the start of any improvements. If during the last month of the term Tenant has removed all or substantially all of Tenant's property therefrom, Landlord may immediately enter and alter, renovate, and redecorate the Premises without elimination or abatement of rent and without liability to Tenant for any compensation and such acts shall have no effect upon this Lease. If Tenant is not personally present to open and permit any entry into the Premises at any time when for any reason an entry therein shall be necessary or permissible, Landlord or its agents may enter the Premises without rendering Landlord or such Landlord or such agents liable therefore (if during such entry Landlord or its agents accord reasonable care to Tenant's property), and without any manner affecting the obligations and covenants of this Lease. Landlord's right to re-entry shall not be deemed to impose upon Landlord any obligation, responsibility, or liability for the care, supervision or repair of the Premises other than herein provided; except that Landlord shall use reasonable care to prevent loss or damage to Tenant's property resulting from Landlord's entry and shall comply with patient privacy laws and regulations as set forth in HIPAA. Landlord shall have the right at any time, without effecting an actual or constructive eviction and without incurring any liability to Tenant therfor, to change the arrangement or location of entrances or passageways, doors and doorways, corridors, elevators, stairs, toilets or other public parts of the Building and to change the name, number or designation by which the Building is commonly known if Landlord provides adequate alternative access to the premises, stairs and toilets. If Landlord takes any action permitted under this Section 20 and, as a result of such action, Tenant cannot use one (1) or more of its patient rooms, rent shall be abated proportionately if a patient of Tenant would otherwise have occupied such patient room during the period in which such room was unusable.

21. **DESTRUCTION OF PREMISES; EMINENT DOMAIN.**

a. In the event of a partial destruction of the Premises during the term of this Lease from any cause, Landlord shall forthwith repair the same, provided such repair can be made within sixty (60) days under laws and regulations; and in such event rent will be abated until the damage is repaired, in proportion to the part of the Premises which is so rendered untenantable; provided, that if (1) such damage was as a result, in whole or in part, of the negligence or willful misconduct of Tenant; and (2) Landlord maintains loss of rent insurance in commercially reasonable amounts and is unable to collect proceeds under such insurance due to Tenant's negligence or willful misconduct, then rent shall not be abated. In addition to the above, in the event that the Building is destroyed to the extent of not less than thirty-three and one-third percent (33 1/3%) of the replacement cost thereof, Landlord may elect to terminate this Lease, whether or not the Premises are insured, by written notice to Tenant. A total destruction of the Building in which the said Premises are situated shall terminate this Lease.

Notwithstanding the aforesaid provisions, in the event the damage caused by the partial destruction of the Premises cannot be repaired for less than Five Hundred Thousand and No/100 Dollars ($500,000) or if there is 18 months or less remaining on the Lease Term, then either Landlord or Tenant may terminate this Lease upon written notice to the other.

b. For the purposes of this Lease, the word "condemned" is coextensive with the phrase "right to eminent domain," that is, the right of the people or government to take property for government use, and shall include the intention to condemn expressed in writing as well as the filing of any action or proceeding for condemnation.

c. If any action or proceeding is commenced for the condemnation of the Premises or any portion thereof, or if Landlord is advised in writing by any government (federal, state or local) agency or department or bureau thereof, or any entity or body having the right or power of condemnation, of its intention to condemn all or any portion of the Premises at the time thereof, or if the Premises or any part or portion thereof be condemned through such action, then and in any of said events: (a) Landlord may, without any obligation or liability to Tenant, and without affecting the validity and existence of this Lease other than as hereafter expressly provided, agree to sell and/or convey to the condemnor, without first requiring that any action or proceeding be instituted, or if such action or proceeding shall have been instituted, without requiring any trial or hearing thereof, and Landlord is expressly empowered to stipulate to judgment therein, the part and portion of the Premises sought by the condemnor, free from this Lease and the rights of Tenant hereunder; or (b) Tenant shall have no claim against Landlord nor be entitled to any part or portion of the amount that may be paid or awarded as a result of the sale, for the reasons as aforesaid, or condemnation of the Premises or any part or portion thereof. Tenant is hereby assigning, transferring, and setting over unto Landlord any interest, if any, which Tenant would, but for this provision, have in, to, upon or against the Premises or any part or portion thereof, or the amount agreed to be paid and/or awarded and paid to Landlord, excepting only Tenant shall be entitled to seek to recover as against the condemnor, and Landlord shall have no claim for or thereto for Tenant's trade fixtures and any removable structures and improvements erected and made by Tenant to or upon the Premises which Tenant is entitled to remove at the expiration of this Lease.

d. If only a part of the Premises is condemned and taken and the remaining portion thereof is not suitable for purposes for which Tenant has leased said Premises, either Landlord or Tenant shall have the option to terminate this Lease at the time of such taking. If by such condemnation and taking only a part of the Premises is taken, and the remaining part thereof is suitable for the purposes for which Tenant has leased said Premises, this Lease shall continue, but the rental shall be reduced in an amount proportionate to the percentage that the floor area of that portion of the Premises taken by eminent domain bears to the floor area of the entire Premises.

22. **TERMINATION.**

a. **Change in Control of Tenant.** If, as a result of a merger or consolidation of Tenant into or with another entity or a sale, exchange, or other disposition of the majority of the shares in Tenant, a Disqualified Person becomes the owner of the majority of the shares in Tenant, Landlord shall have the right to terminate this Lease upon ninety (90) days notice to

Tenant. A "Disqualified Person" shall mean any person or entity that owns, operates or is affiliated with a general acute care hospital within a 25-mile radius of the Premises.

b. **Termination For Changes In Law.** In the event that any governmental or nongovernmental agency, or any court or administrative tribunal passes, issues or promulgates any new, or change to any existing, law, rule, regulation, standard, interpretation, order, decision or judgment (individually or collectively, "Legal Event"), which a party (the "Noticing Party") reasonably believes (i) materially and adversely affects either party's licensure, accreditation, certification, or ability to refer, to accept any referral, to present a bill or claim, or to receive payment or reimbursement from any governmental or non-governmental payor, or (ii) indicates a Legal Event with which the Noticing Party desires further compliance, or (iii) results in a material and adverse reduction of the Noticing Party's reimbursement by the Medicare program, then, in either event, the Noticing Party may give the other party thirty (30) days prior written notice of its intent to amend or terminate this Agreement. Notwithstanding the foregoing, the Noticing Party may propose an amendment to the Agreement to take into account the Legal Event, and, if accepted by the other party prior to the end of the thirty (30) day notice period, the Agreement shall be amended as of the date of such acceptance and if not amended shall automatically terminate.

c. **Bankruptcy.** If a general assignment is made by Tenant for the benefit of creditors, or any action is taken by Tenant under any insolvency or bankruptcy act (and if involuntary, the action is not dismissed within sixty (60) days), or if a receiver is appointed to take possession of all or substantially all of the assets of Tenant (and Tenant fails to terminate such receivership within sixty (60) days after such appointment), or if Tenant is adjudicated a bankrupt, then this Lease shall terminate upon the occurrence of any such contingency and shall expire as fully and completely as if the day of the occurrence of such contingency were the date specified in this Lease for the expiration thereof. Tenant will then quit and surrender the Premises to Landlord.

d. Default. (i) By Tenant. If Tenant fails to pay any rent or other sum due hereunder at the time set forth in this Lease, and if Tenant continues to fail to pay same within five (5) days after written notice thereof (provided, that Landlord shall be required to give notice only once in any 12-month period), or in the event Tenant fails to perform or observe any other covenant to be performed by Tenant under this Lease and continues to fail to perform or observe same for a period of fifteen (15) days after receipt of written notice from Landlord pertaining thereto (or a reasonable period of time, using the due diligence, if such default cannot be cured within said fifteen (15) day period), then Tenant shall be deemed to have breached this Lease and Landlord, at its option, may have any one or more of the following remedies, in addition to other rights or remedies it may have at law or in equity: (i) continue this Lease in effect by not terminating Tenant's right of possession of the Premises, and thereby be entitled to enforce all Landlord's rights and remedies under this Lease, including the right to recover the rent specified in this Lease as it becomes due under this Lease; or (ii) terminate Tenant's right to possession of the Premises, thereby terminating this Lease, and recover as damages from Tenant: (a) the worth at the time of award of the unpaid rent which had been earned at the time of termination of the Lease; and (b) the worth at the time of award of the amount by which the unpaid rent for the balance of the term after the time of award exceeds the amount of rental loss that Tenant proves could be reasonably avoided; or (iii) in lieu of, or in addition to, bringing an action for any or all

of the recoveries described above, bring an action to recover and regain possession of the Premises in the manner provided by the laws of unlawful detainer then in effect in the state in which the Premises are located.

(ii) By Landlord. Upon a Landlord default, Tenant's sole and exclusive remedy shall be to bring an action against Landlord in a court of appropriate jurisdiction to recover Tenant's actual damages from such default. In no event shall Tenant be entitled to set off or deduct the amount of any such damage from sums due to Landlord under this Lease. In no event shall Landlord every be liable to Tenant for any consequential or punitive damages by virtue of any breach of this Lease by Landlord.

e. **Immediate Termination.** Each party represents and warrants that neither it nor its employees or agents (i) have been convicted of a federal health care crime; or (ii) have been excluded from participation in any federal health care programs. A party shall notify the other party immediately if any of the foregoing occurs, whereupon the non-breaching party shall have the right to immediately terminate this Lease for cause. Notwithstanding the above, if a party's employee or agent is convicted or excluded, the breaching party can sure same by terminating the employment or agency relationship in question.

23. **SURRENDER OF LEASE.** The voluntary or other surrender of this Lease by Tenant, or mutual cancellation thereof, shall not cause a merger at law and shall, at the option of Landlord, terminate all or any existing subleases or subtenancies, or may, at the option of Landlord, operate as an assignment of any or all such subleases or subtenancies to Landlord.

24. **RULES AND REGULATIONS.** Tenant shall comply with all reasonable rules and regulations now or hereinafter adopted by Landlord during the existence of this Lease posted in or about the said Building, or otherwise brought to the notice of Tenant, both in regard to the Building as a whole and to the Premises herein leased. Current rules and regulations governing Tenant's conduct in the Building are attached hereto as Exhibit A. If there is a conflict between the rules and regulations and this Lease, this Lease shall control.

25. **COMPLIANCE WITH LAWS AND REGULATIONS.**

a. **In General.** During the Term of this Lease, each party shall comply with applicable federal, state and local laws and regulations.

b. **No Violation of Law.** Each party represents and warrants to the other party that it shall not knowingly violate any federal, state or local laws or regulations by entering into this Lease or performing its obligations hereunder.

c. **Exclusion, Debarment, or Suspension.** Each party represents and warrants that neither it nor any of its employees have been excluded from participation in any federal health care program, as defined under 42 U.S.C. § 1320a-7b(f), for the provision of items or services for which payment may be made under such federal health care programs, nor been debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency. Each party shall promptly notify the other party in the event that

such party or any employee of such party is excluded from participation in, or is otherwise unable to participate in, a federal health care program, or is debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any federal department or agency. In the event that either party is so excluded, debarred, suspended or can no longer participate in any federal health care program, the other party shall have the right immediately to terminate this Agreement.

d. **No Condition of Referrals.** Neither the selection of Tenant nor the terms and conditions of this Lease shall be conditioned on Landlord or Tenant (i) making referrals to the other; (ii) being in a position to make or influence referrals to the other, or (iii) otherwise generating business for the other.

26. **NOTICES.** All notices hereunder shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier addressed at the place identified on the signature page below.

27. **ASSIGNMENT AND SUBLETTING.** Tenant shall have the right, upon written notice to Landlord, to assign this Lease or sublet the Premises to any entity controlling, controlled by or under common control with Tenant except to a Disqualified Person. Otherwise, Tenant shall not assign or sublease all or any part of the Premises under this Lease, except with the prior written consent of Landlord. This Lease is assignable by Landlord without consent.

28. **ATTORNEY'S FEES.** In the event of any legal or equitable action arising out of this Lease, the prevailing party shall be entitled to recover all fees, costs and expenses, together with reasonable attorney's fees incurred in connection with such action. The fees, costs, and expenses so recovered shall include those incurred in prosecuting or defending any appeal and shall be awarded for any supplemental proceedings until final judgment is satisfied in full. The prevailing party shall also be entitled to reasonable attorney's fees incurred to collect or enforce the judgment.

29. **GOVERNING LAW.** This Lease shall be governed by the laws of the state in which the Premises are located.

30. **INTENTIONALLY OMITTED.**

31. **INTENTIONALLY OMITTED.**

32. **ESTOPPEL CERTIFICATES.** Tenant shall, at any time and from time to time, upon not less than twenty (20) days' prior request by Landlord, execute, acknowledge, and deliver to Landlord, or to such other persons who may be designated in such request, a statement in writing certifying that this Lease is unmodified and in full force and effect (or if there have been modifications, that the same is in full force and effect as modified and stating the modifications) and, if so, the dates to which the rent and any other charges have been paid in advance, and containing other statements and certifications reasonably requested by Landlord. It is intended

that any such statement delivered pursuant to this Section may be relied upon by Landlord and any prospective purchaser or encumbrancer (including assignee) of the Premises.

33. **QUIET ENJOYMENT.** Landlord warrants that Tenant shall be granted peaceable and quiet enjoyment of the Premises free from any eviction or interference by Landlord if Tenant pays the rent and other charges provided herein, and otherwise fully and punctually performs the terms and conditions imposed on Tenant.

34. **GENERAL PROVISIONS.**

a. The waiver by Landlord of any breach of any term, covenant, or condition herein contained shall not be deemed to be a waiver of any subsequent breach of the same or any other term, covenant or condition contained herein. The acceptance of rent hereunder shall not be construed to be a waiver of any breach by Tenant of any term, condition or covenant of this Lease.

b. It is understood and agreed that the remedies herein given to Landlord shall be cumulative, and the exercise of any one remedy of Landlord shall not be to the exclusion of any other remedy.

c. The covenants and conditions herein contained shall, subject to the provisions as to assignment, apply to and bind the heirs, successors, executors, administrators, and assigns of all of the parties hereto; and all of the parties hereto shall be jointly and severally liable hereunder.

d. Time is of the essence of this Lease.

e. This Lease, including any Exhibits referred to herein, cover in full each and every agreement of every kind or nature, whatsoever kind or nature are merged herein. Landlord has made no representations or promises whatsoever with respect to the Premises, except those contained herein, and no other person, firm or corporation has at any time had any authority from Landlord to make any representations or promises on behalf of Landlord; and Tenant expressly agrees that if any such representations or promises have been made by others, Tenant hereby waives all right to rely thereon. No verbal agreement or implied covenant shall be held to vary the provisions hereof, any statute, law or custom to the contrary notwithstanding.

f. The captions of the sections of this Lease are for convenience only, and do not in any way limit or amplify the terms and provisions of this Lease.

g. If any term, covenant, condition or provision of this Lease is held by a court competent of jurisdiction to be invalid, void or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

35. **CORPORATE AUTHORITY.** If Tenant executes this Lease as a corporation, each of the persons executing this Lease on behalf of Tenant does hereby personally covenant and warrant that Tenant is a duly authorized and existing corporation, that Tenant was and is

qualified to do business in the state in which the Premises are located, that the corporation has full right and authority to enter into this Lease, and that each person signing on behalf of the corporation was authorized to do so. If Landlord executes this Lease as a corporation, each of the persons executing this Lease on behalf of Landlord does hereby personally covenant and warrant that Tenant is a duly authorized and existing corporation, that Landlord was and is qualified to do business in the state in which the Premises are located, that the corporation has full right and authority to enter into this Lease, and that each person signing on behalf of the corporation was authorized to do so.

36. **NEGOTIATED INSTRUMENT.** This is a negotiated agreement between the parties hereto, and shall not be construed against any party as a result of his or her attorney having drafted this Agreement. Both parties have had the opportunity to have their respective attorneys review this Agreement and fully understand the terms of this Agreement.

37. **COMPLIANCE OBLIGATIONS.** Tenant has received, read, and understood Tenet's Standards of Conduct and Tenet's Compliance Program and Tenet's policies and procedures related to the Deficit Reduction Act of 2005, Anti-Kickback Statute and the Stark Law. Landlord and Tenant each shall comply with the Deficit Reduction Act of 2005, Anti-Kickback Statute and the Stark Law. Tenet's Standards of Conduct, summary of Compliance Program, and policies and procedures, including a summary of the Federal False Claims Act and applicable state false claims laws (collectively "False Claims Laws") with descriptions of penalties and whistleblower protections pertaining to such laws, are available at: http://www.tenethealth.com/TenetHealth/OurCompany/EthicsBusinessConduct. Tenant may make available to any employees providing services to Hospital the Standards of Conduct and information concerning Tenet's Compliance Program. Hardcopies of any information shall be made available upon request. Further, the parties to this Agreement certify that they shall not violate the Anti-Kickback Statute and Stark Law, and shall abide the Deficit Reduction Act of 2005, as applicable, in performing services to Hospital.

38. **EXCLUSION LISTS SCREENING.** Tenant shall screen all of its current and prospective owners, legal entities, officers, directors, employees, contractors, and agents ("Screened Persons"), if any, against (a) the United States Department of Health and Human Services/Office of Inspector General List of Excluded Individuals/Entities (available through the Internet at http://www.oig.hhs.gov), and (b) the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://www.epls.gov) (collectively, the "Exclusion Lists") to ensure that none of the Screened Persons are currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal healthcare programs or in Federal procurement or nonprocurement programs, or have been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a), but have not yet been excluded, debarred, suspended, or otherwise declared ineligible (each, an "Ineligible Person"). If, at any time during the term of this Agreement any Screened Person becomes an Ineligible Person or proposed to be an Ineligible Person, Tenant shall immediately notify Hospital of the same. Screened Persons shall not include any employee, contractor or agent who is not providing services to Hospital under this Agreement.

39. **NON-COMPETITION COVENANT.**

a. Tenant, on behalf of itself and its subsidiaries, covenants and agrees that, during the Term hereof, it shall not, directly or indirectly, within a 25 - mile radius of the Host Facility, own, manage, operate, control, participate in the management or control of, or act as agent for, lend its name to or initiate or maintain or continue any interest whatsoever in a general acute care hospital (a "Competing Tenant Facility").

b. If Tenant, or an affiliate, acquires another entity (the "Acquired Tenant Entity"), whether by asset or stock purchase, merger or consolidation, the restriction immediately above will not apply to any Competing Tenant Facility with respect to which Tenant, or an affiliate, would own, manage, operate, etc. as a result of such acquisition; provided, however, that if such Competing Tenant Facility acquired as part of such acquisition accounts for more than fifteen percent (15%) of the Acquired Tenant Entity's net revenues at the time of the acquisition, then Tenant, or its affiliate, will sell or otherwise dispose of such Competing Tenant Facility within six (6) months after such acquisition.

c. Tenant acknowledges that this non-competition covenant is essential to the continued success of Landlord and that Landlord would sustain irreparable harm and damage in the event that Tenant violates the covenant and that damages would not provide an adequate remedy to Landlord. Tenant further acknowledges that compliance with this non-competition covenant will not constitute an unreasonable hardship or deprive it of the opportunity to conduct its intended business.

d. Landlord, on behalf of itself and its subsidiaries and affiliates covenants and agrees that, during the Term hereof, it shall not, directly or indirectly, within a 25 - mile radius of the Premises, own, manage, operate, lease to, control, participate in the management or control of, or act as agent for, lend its name to or initiate or maintain or continue any interest whatsoever in a long term acute care hospital (defined as hospitals or hospitals-within-hospitals with an average length of stay of not less than 25 days, or meeting any successor definition of a long term acute care hospital for Medicare purposes) (such hospital, a "Competing Landlord Facility").

e. If Landlord, or an affiliate, acquires another entity (the "Acquired Landlord Entity"), whether by asset or stock purchase, merger or consolidation, the restriction immediately above will not apply to any Competing Landlord Facility with respect to which Landlord, or an affiliate, would own, manage, operate, etc. as a result of such acquisition; provided, however, that if such Competing Landlord Facility acquired as part of such acquisition accounts for more than fifteen percent (15%) of the Acquired Landlord Entity's net revenues at the time of the acquisition, then Landlord, or its affiliate, will sell or otherwise dispose of such Competing Landlord Facility within six (6) months after such acquisition.

f. Landlord acknowledges that this non-competition covenant is essential to the continued success of Tenant and that Tenant would sustain irreparable harm and damage in the event that Landlord violates the covenant and that damages would not provide an adequate remedy to Tenant. Landlord further acknowledges that compliance with this non-competition covenant will not constitute an unreasonable hardship or deprive it of the opportunity to conduct its intended business.

40. **COUNTERPART.** This Lease may be executed in one or more counterparts, each of which shall be deemed an original but all of which counterparts collectively shall constitute one instrument representing the lease among the parties hereto. It shall not be necessary that any one counterpart be signed by all of the parties hereto as long as each of the parties has signed at least one counterpart.

41. **FACSIMILE SIGNATURES.** Any party to this Lease or to any other document contemplated herein may execute a counterpart of same and transmit the page bearing his or her signature via facsimile to any other party, in which case the party transmitting the facsimile signature shall be deemed to have executed and delivered a complete original counterpart of this Lease or such other document as the case may be, and shall be bound to the same extent as if it had done so. Any party executing this Lease or any other document contemplated herein via facsimile signature shall also forward a complete manually executed counterpart of same to each other party, although failure to do so shall not change the binging effect of the facsimile signature.

42. **GENERAL STORES.** At the request of Tenant, Landlord shall provide all non-purchasing related general store functions, including, but not limited to, shipping, receiving, and distribution of mail, equipment or other supplies delivered for Tenant at the building. The cost of same is included in the rent payments to Landlord.

43. **PERSONAL PROPERTY FURNISHED BY LANDLORD.** Landlord shall provide to Tenant the personal property described on Exhibit B.

44. **DISASTER PREPAREDNESS.** Tenant has developed a disaster preparedness plan that meets the requirements of all applicable federal and state laws. The disaster preparedness plan includes a provision for the evacuation of the patients of Tenant, and Tenant agrees that it is solely responsible for the evacuation and care of its patients at all times and in the event of a disaster.

(Signature page will follow)

LANDLORD:

AMISUB (SFH), INC.
D/B/A SAINT FRANCIS HOSPITAL

By: _____
Name: David L. Archer
Title: President & CEO
Date: 3/30/10
Address: 5959 Park Avenue
Memphis, TN 38119

TENANT:

SELECT SPECIALTY HOSPITAL – MEMPHIS, INC.

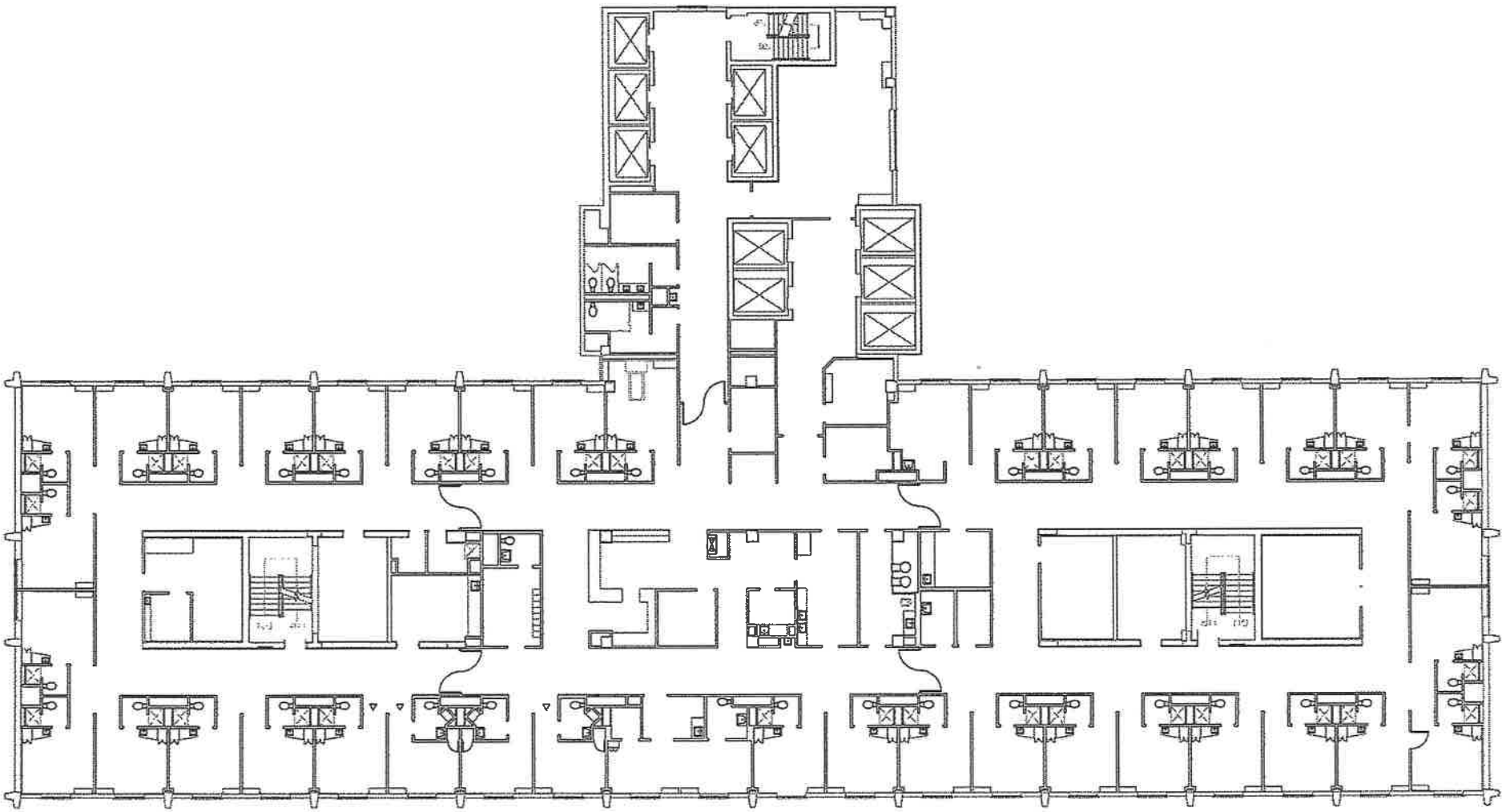
By: Patricia A. Rice
Name: Patricia A. Rice
Title: Vice President
Date: March 29, 2010
Address: 4714 Gettysburg Road
Mechanicsville, PA 17055
Attn: Chief Operating Officer

With a copy to:

Select Medical Corporation
4714 Gettysburg Road
Mechanicsville, PA 17055
Attn: General Counsel

SCHEDULE 1-A

[Attach Description/Floor Plan of Clinical Premises]



SCHEDULE 1-B

[Attach Description/Floor Plan of Administrative Office Premises]

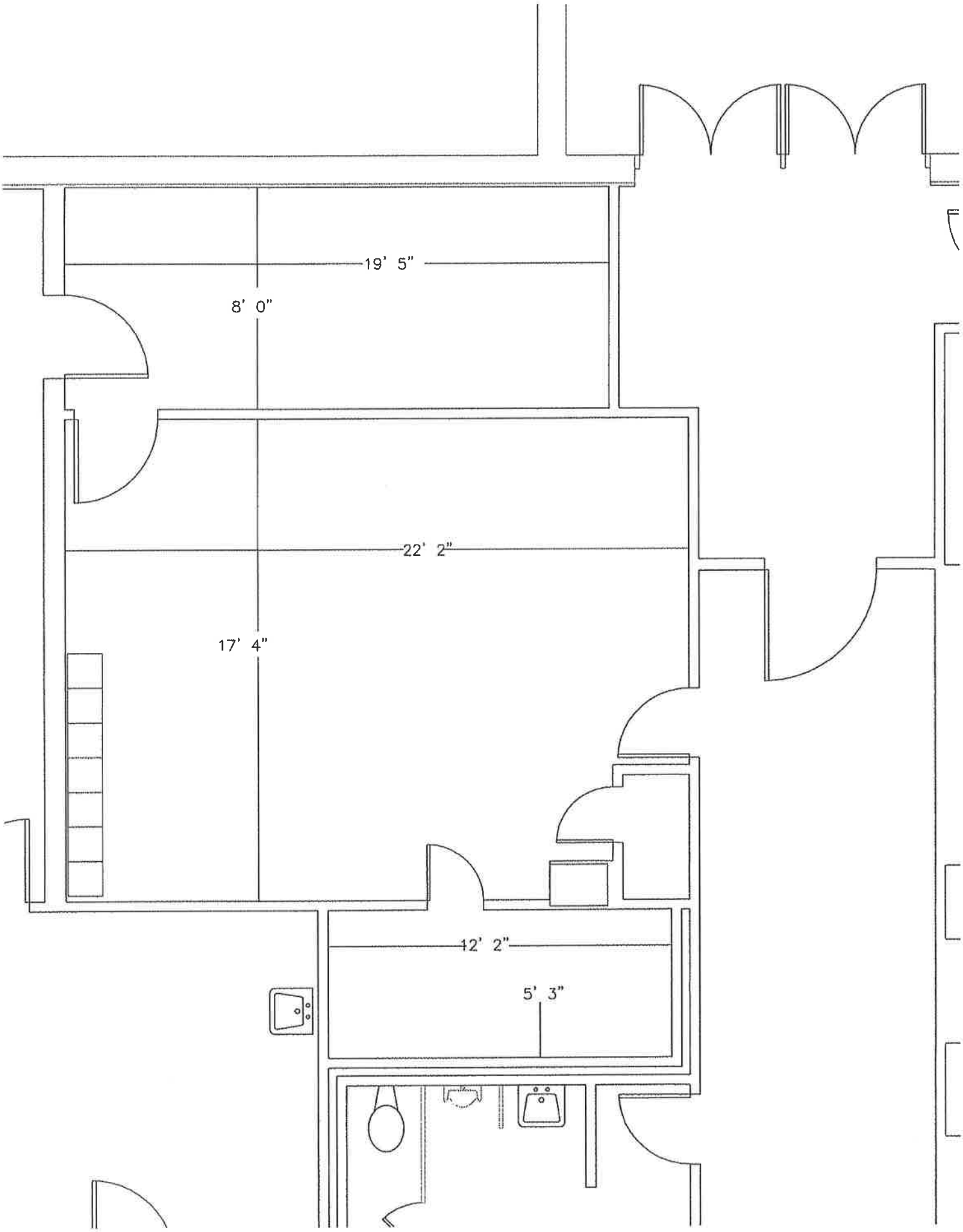

19' 5"
8' 0"
22' 2"
17' 4"
12' 2"
5' 3"

EXHIBIT A
RULES AND REGULATIONS
ATTACHED TO AND MADE A PART OF THIS LEASE

1. The sash doors, sashes, windows, glass doors, lights, and skylights that reflect or admit light into the halls or other places of the Building shall not be covered or obstructed, except as designated by Landlord. All doors opening onto public corridors shall be kept closed, except when in use for ingress and egress.

2. No sign, nor advertisement, nor notice, shall be inscribed, painted or fixed on or to any part of the outside or inside of the Building unless it is of such color, size and style, and in such a place upon or in the Building, as may be designated by Landlord, in its sole discretion. All signs on doors or window glass will be painted for tenants by Landlord, but the cost of painting shall be paid by tenant.

3. Electric wiring of any kind shall be introduced and connected as directed by Landlord and no boring nor cutting for wires will be allowed except with the consent of Landlord.

4. No additional lock or locks shall be placed by tenants on any door in the Building unless written consent of Landlord shall have first been obtained. Two (2) keys will be furnished by Landlord for each suite, and any additional keys required must be obtained from Landlord. Tenants shall be charged for additional keys at Landlord's cost. All keys shall be surrendered to Landlord upon termination of the tenancy. Tenant will not change any of his/her/its locks without first notifying Landlord in writing of such change.

5. Tenant shall not employ any person or persons other than the janitor of Landlord for the purposes of cleaning the leased premises without the consent of Landlord. Landlord shall be in no way responsible to any tenant for any loss of property from the leased premises, however occurring, or for any damage done to the effects of any tenants by the janitor or any other of Landlord's employees, or by any other person. Janitor's service will not include the cleaning of carpets and rugs.

6. All freight must be moved into, within and out of the Building under the supervision of Landlord, and according to such regulations as may be posted in the Office of the Building, but Landlord will not be responsible for loss or damage to such freight from any cause.

7. The requirements of tenants will be accommodated only upon application at the Office of the Building. Landlord's employees shall not perform any work nor do anything outside of their regular duties unless under special instructions from the Office, and no employee shall admit any person (tenant or otherwise) to any office without instructions from the Office of the Building.

8. Landlord reserves the right to change the name of the Building, and from time to time make such alterations and repairs as deemed advisable by Landlord to the exterior of the Building and to the lobby and other public areas of which the leased premises are a part.

9. The water and wash closets and other plumbing fixtures shall not be used for any purpose other than those for which they were constructed, and no sweeping, rubbish, rags or other substances shall be thrown therein. All damages resulting from any misuse of the fixtures shall be borne by the tenant who, or whose servants, employees, agents, visitors, or licensees shall have caused the same.

10. No tenant shall mark, paint, drill into, or in any way deface any part of the premises or the Building. No boring, cutting or stringing of wires or laying of linoleum or other similar floor coverings shall be permitted, except with the prior written consent of Landlord, and as Landlord may direct. Tenant may hang pictures and plaques in the leased premises.

11. No bicycles, vehicles or animals of any kind shall be brought into or kept in or about the leased premises, and no cooking shall be done or permitted by any tenant on the premises, except that the preparation of coffee, tea, hot chocolate and similar items for tenants and their employees shall be permitted. No tenant shall cause or permit any unusual or objectionable odors to be produced upon or permeate the premises.

12. The leased premises shall not be used for manufacturing or for the storage of merchandise except as such storage may be incidental to the use of the premises for medical practice purposes.

13. No tenant, nor any tenant's servants, employees, agents, visitors or licensees, shall at any time bring or keep upon the leased premises any inflammable, combustible or explosive fluid, chemical or substance, other than chemicals necessary for the practice of medicine.

14. Canvassing, soliciting and peddling in the Building are prohibited and each tenant shall cooperate to prevent the same.

15. At any time while security is in charge of the Building, any person entering or leaving the Building may be questioned by him as to his/her business in the building; and anyone not satisfying the watchman of his/her right to enter the Building may be removed by him.

16. Landlord reserves the right to make such other and further rules and regulations as in its judgment may from time to time be reasonably necessary for the safety and cleanliness of and for the preservation of good order in the Building and leased premises therein.

EXHIBIT B

Personal Property Provided by Landlord

SSH-Memphis
Saint Francis Hospital (Host) Patient Room Property

Saint Francis Hospital has the following furniture/property in each patient room:

1 Bedside Table
1 Bedside Cabinet
1 Family Chair
1 Television

Total Patient Room Property Provided by Host:
39 Bedside tables
39 Bedside Cabinets
39 Family Chairs
39 Televisions

Additional Property:

Nurse Call System
2 computers for host services order entry

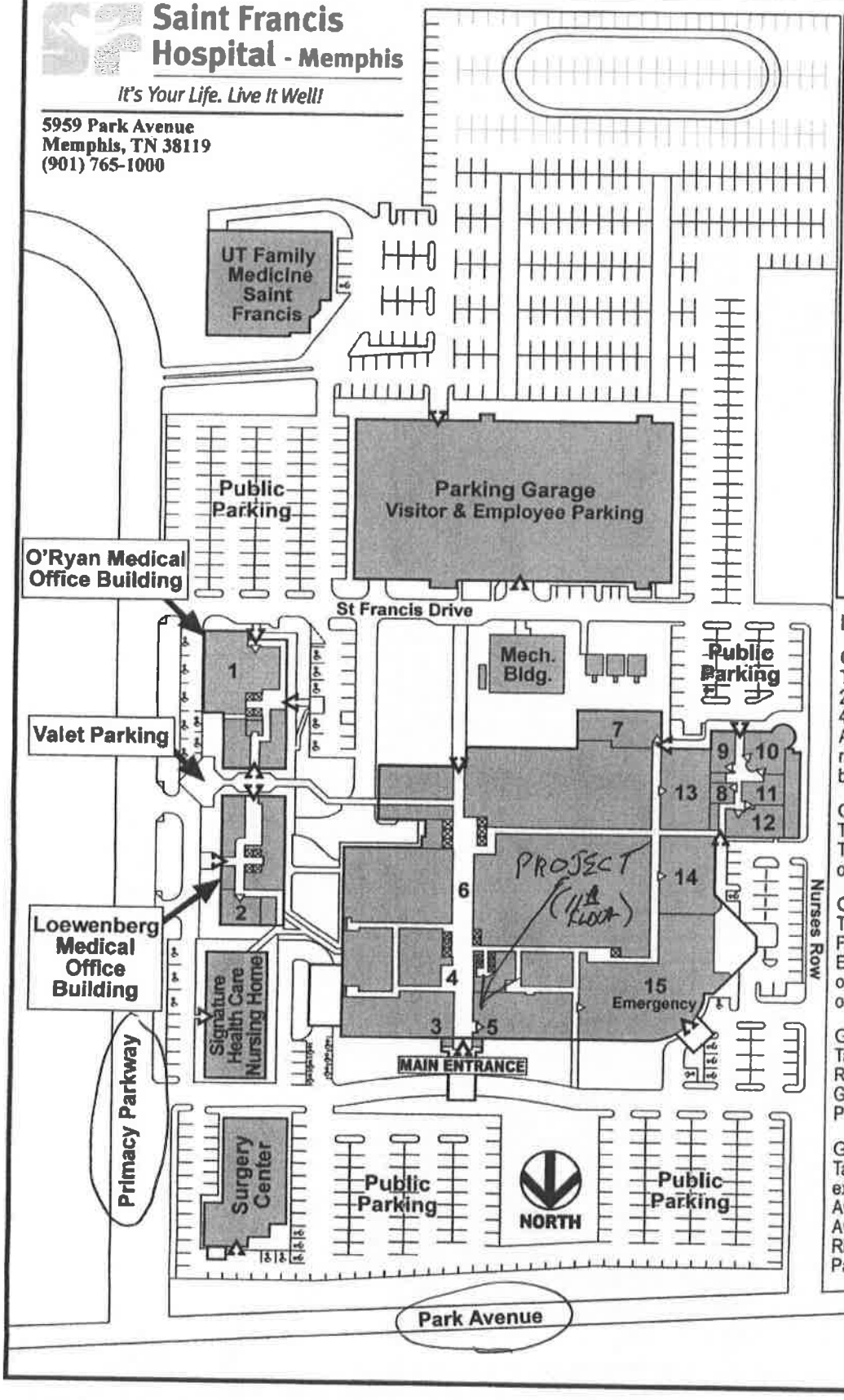
B.II.A.--Square Footage and Costs Per Square Footage Chart

B.III.--Plot Plan

Saint Francis Hospital - Memphis

It's Your Life. Live It Well!

5959 Park Avenue
Memphis, TN 38119
(901) 765-1000



1	Total Care
2	Center for Surgical Weight Loss
3	Outpatient / Registration
4	Information Desk
5	Cardiac Care Center
6	Pre-Admission Testing/PAT
7	Sweeney YMCA Fitness Center
8	Saint Claire Hall
9	Saint Catherine Hall
10	Longinotti Auditorium
11	Outpatient Memphis Heart Alliance Cath Lab
12	Women's Center
13	Physical Therapy
14	Radiation/Oncology
15	Emergency Center/Chest Pain Emergency Center
⊠⊠	Elevators
▷	Entrance
▷	Interior Entrance

Driving Directions ...

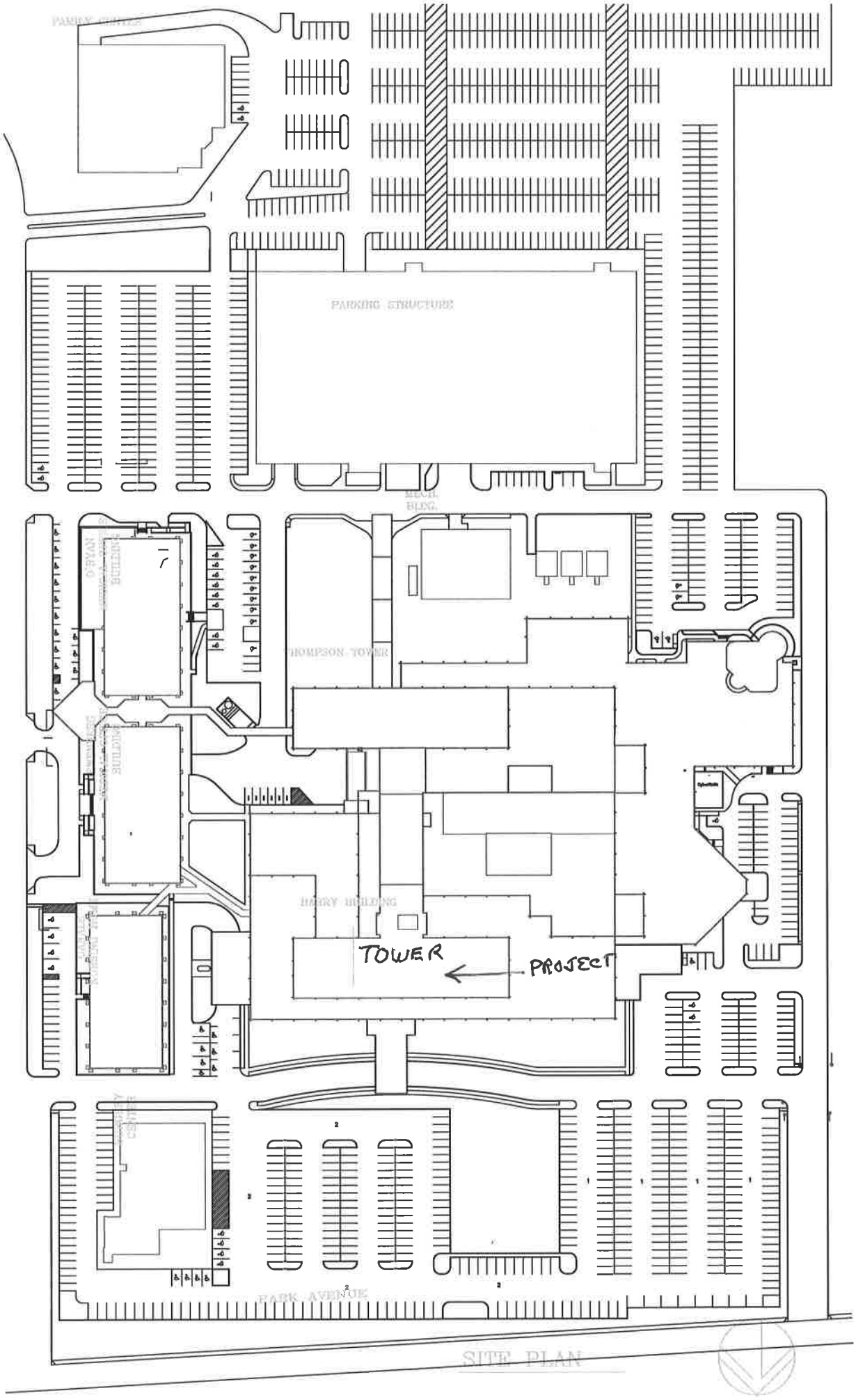
Gpn !epx oupx olvjb\buf st ubuf
Take I-240 East toward Nashville. Follow 240 around the city past the Nashville (I-40)exit. Continue on 240 to the Poplar Avenue East exit. Go east one block, turn right on Ridgeway, then turn right one block on Park Avenue.

Gpn !Epx oupx olvjb!QoqsbtBwf ovf
Take Poplar Avenue East to Ridgeway. Turn right on Ridgeway, then turn right one block on Park Avenue.

Gpn !Nf n qi jt l.buf sobjpobnBjsqpsu
Take Interstate 240 East toward Nashville. Follow 240 to Germantown/Poplar Avenue East exit. Go East one block, turn right on Ridgeway, then turn right one block on Park Avenue.

Gpn !Dpnjo svjmn
Take Poplar Avenue (Hwy. 72) West to Ridgeway. Turn left (South) on Ridgeway. Go South one block, then turn right on Park Avenue.

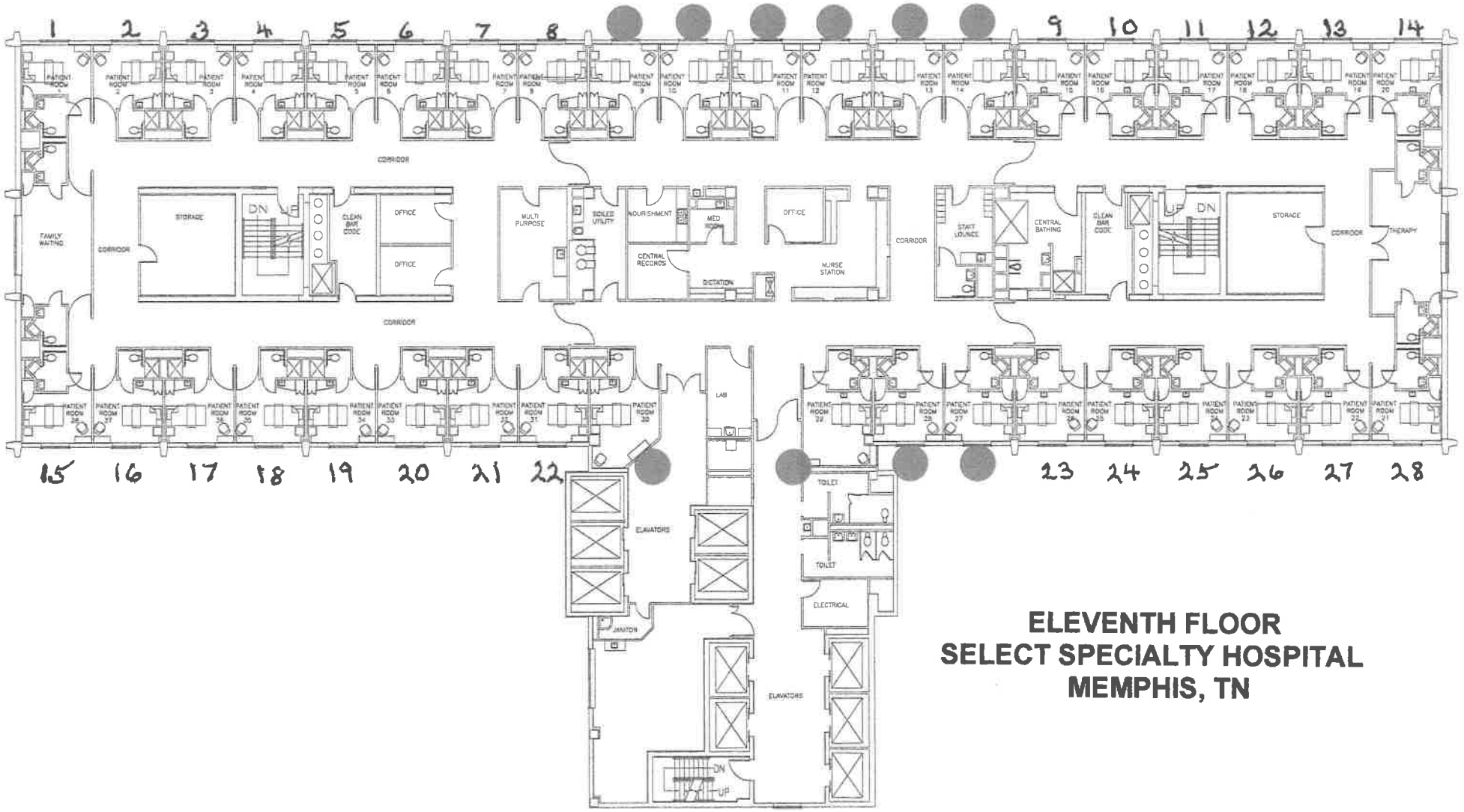
Gpn !Cbt i vjmn
Take I-40 to the I-240, Jackson Mississippi exit. Follow 240 South to the Poplar Avenue East exit. Go East on Poplar Avenue to Ridgeway, turn right on Ridgeway, then turn right one block on Park Avenue.



SITE PLAN

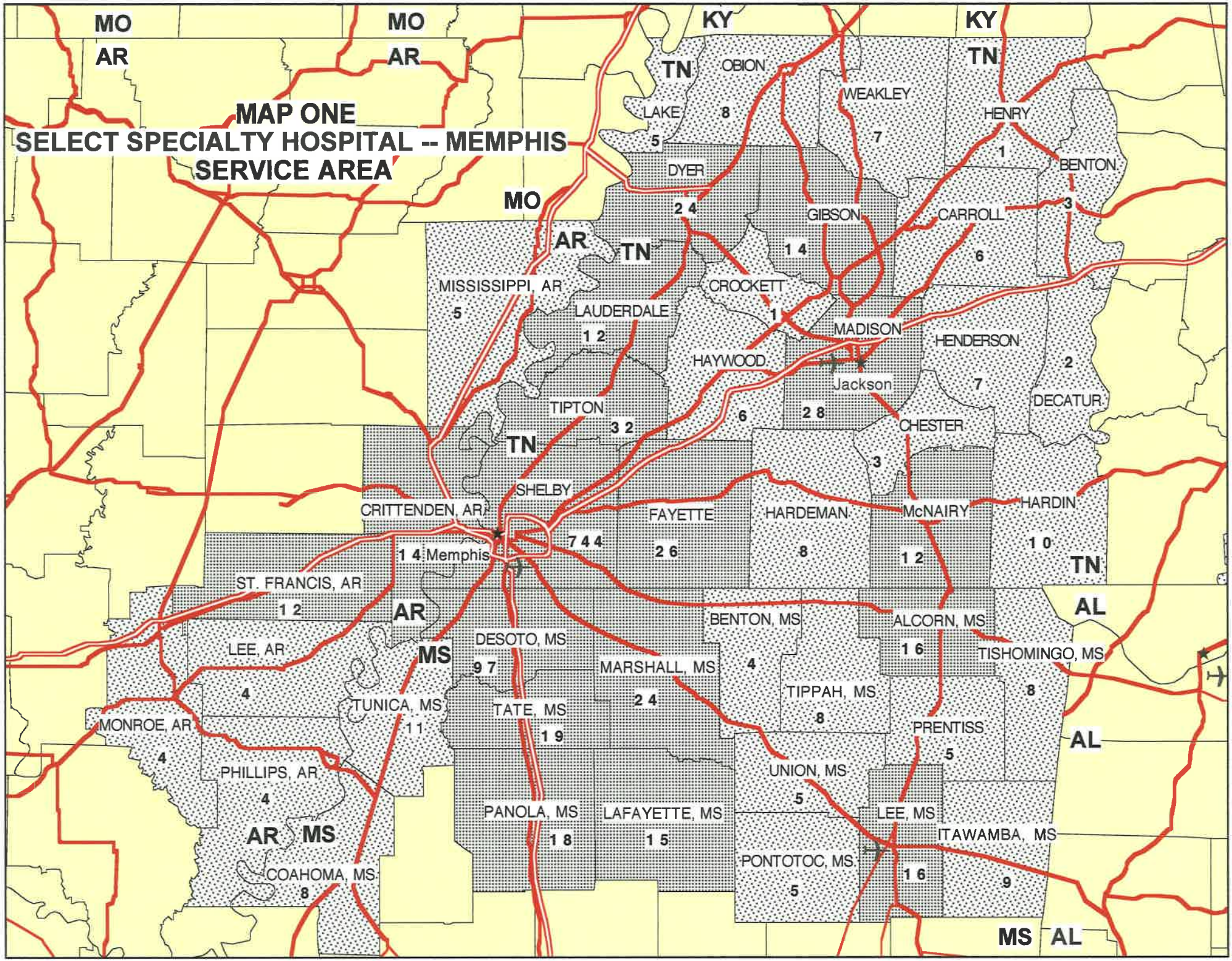
B.IV.--Floor Plan

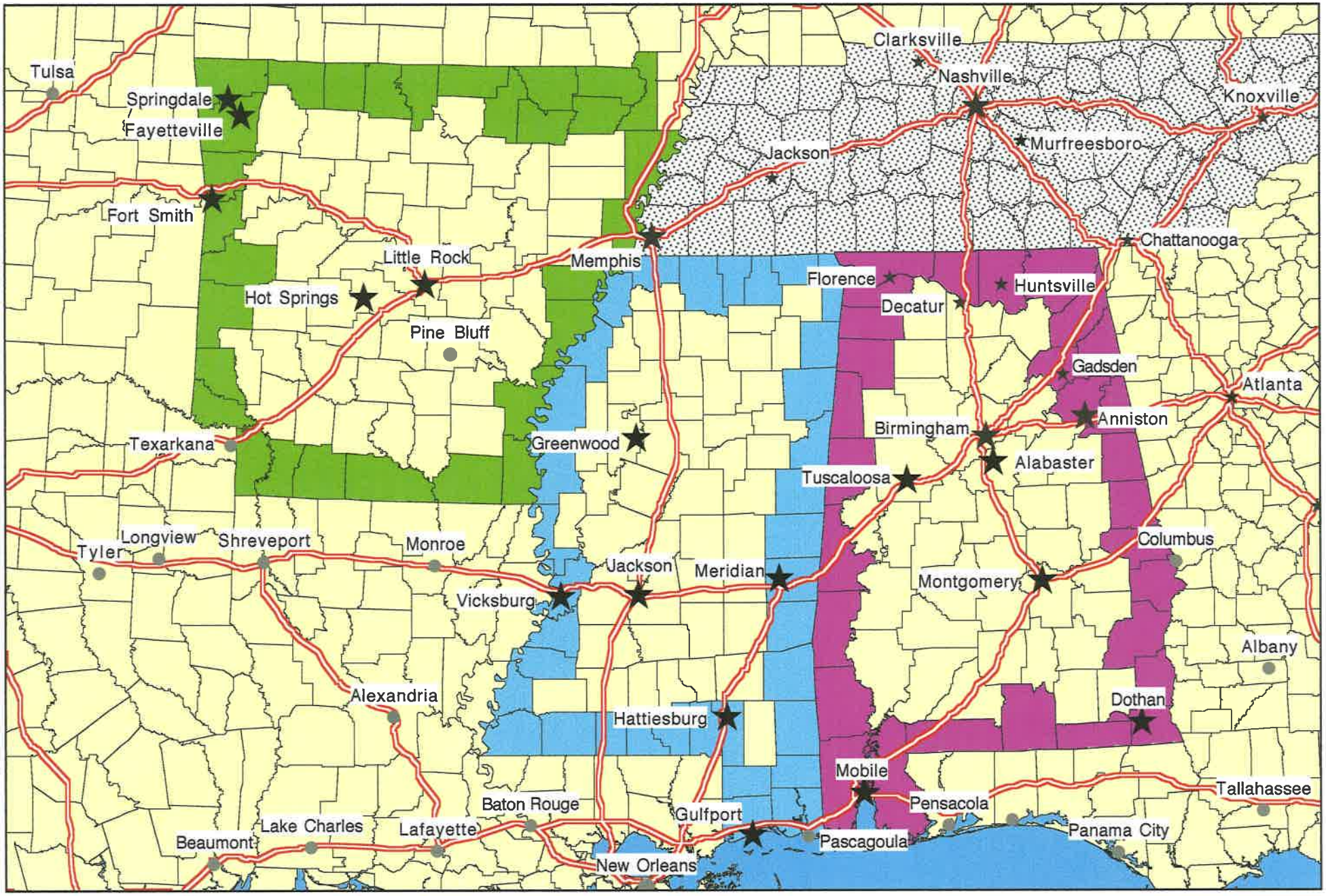
● = 10 LTACH BEDS ALREADY APPROVED FOR LICENSURE (EARLY 2013)
NUMBERED ROOMS = 28 ADDITIONAL LTACH BEDS PROPOSED IN THIS APPLICATION



ELEVENTH FLOOR
SELECT SPECIALTY HOSPITAL
MEMPHIS, TN

C, Need--3
Service Area Maps


MAP ONE
SELECT SPECIALTY HOSPITAL -- MEMPHIS
SERVICE AREA
MO
AR
KY
TN
MS
AL
OBION
LAKE
8
5
WEAKLEY
7
HENRY
1
BENTON
3
DYER
2 4
GIBSON
1 4
CARROLL
6
MISSISSIPPI, AR
5
LAUDERDALE
1 2
CROCKETT
1
MADISON
HENDERSON
2
HAYWOOD
6
Jackson
7
2 8
DECATUR
TIPTON
3 2
CHESTER
3
SHELBY
CRITTENDEN, AR
FAYETTE
2 6
HARDEMAN
8
McNAIRY
1 2
HARDIN
1 0
7 4 4
1 4 Memphis
ST. FRANCIS, AR
1 2
BENTON, MS
4
ALCORN, MS
1 6
TISHOMINGO, MS
8
LEE, AR
4
DESOTO, MS
9 7
MARSHALL, MS
2 4
TIPPAH, MS
8
TUNICA, MS
1 1
TATE, MS
1 9
PRENTISS
5
MONROE, AR
4
PHILLIPS, AR
4
UNION, MS
5
PANOLA, MS
1 8
LAFAYETTE, MS
1 5
LEE, MS
ITAWAMBA, MS
PONTOTOC, MS.
5
1 6
9
COAHOMA, MS
8



SERVICE AREA LOCATION
STATE OF TENNESSEE

C, Economic Feasibility--1
Documentation of Construction Cost Estimate

C, Economic Feasibility--2
Documentation of Availability of Funding

Select MEDICAL
Improving Quality of Life

Martin F. Jackson
Executive Vice President,
Chief Financial Officer

December 14, 2012

Melanie M. Hill, Executive Director
Tennessee Health Facilities Commission
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

Dear Mrs. Hill:

Select Specialty Hospital – Memphis, Inc. is applying for a Certificate of Need to lease, remodel, and license 28 additional inpatient beds leased from Saint Francis Hospital in Memphis, on its 11th floor. This will require a capital expenditure of no more than approximately $3,647,000.

As Chief Financial Officer for Select Medical Corporation, the corporate parent of Select Specialty Hospital – Memphis, Inc., I am writing to confirm that Select Specialty Hospital – Memphis, Inc. will fund the project in cash, and that it currently has sufficient cash reserves and operating income to do so.

Sincerely,

Martin F. Jackson
Executive Vice President & CFO

4714 Gettysburg Road • P.O. Box 2034 • Mechanicsburg, PA 17055
mjackson@selectmedical.com • 717.972.3814 • Fax 717.303.0824
selectmedical.com

C, Economic Feasibility--10
Financial Statements

Y YTD BALANCE SHEET REPORT

ORACLE Applications

lect Medical Corporation
od: DEC-11 Currency: USD
Submitted: 07-DEC-12 15:30:11

COMPANY=422 (Memphis)

	CY2011
Current assets:	
Cash and cash equivalents	0.00
Accounts receivables:	
Patient receivables	10,493,753.77
AR Clearing	(2,453,433.93)
Contractual adjustments	(5,392,725.56)
Allow for doubtful accounts	(494,989.28)
Other receivables	0.00
Prepaid expenses	0.00
Other current assets	123,990.33
Total current assets	2,276,595.33
Affiliates:	
Investments in	0.00
Advances to	15,264,421.30
Total affiliates	15,264,421.30
Property and equipment:	
Land	0.00
Building and improvements	754,831.67
Assets under capital leases	0.00
Furniture and equipment	1,195,159.07
Asset Clearing	0.00
Total fixed assets	1,949,990.74
Less accum. deprec	(1,709,409.17)
Net val property, plant & equip	240,581.57
Construction in progress	0.00
Total property, plant & equip	240,581.57
Other assets:	
Deposits	5,653.12
Prepaid rent	0.00
Goodwill, net	0.00
Other intangibles	0.00
Mgmt service agreements	0.00
Long term investments	0.00
Notes receivable	0.00
Deferred costs, net	0.00
Deferred financing costs, net	0.00
Other noncurrent assets	1,853.34
Total noncurrent assets	7,506.46
Total assets	17,789,104.66
Current liabilities:	
Notes payable	
Current portion of L-T debt:	
Seller notes - current	0.00
Notes and mortgages	0.00
Capital leases	0.00
Accounts payable	933,632.71
Accrued expenses:	
Payroll	0.00
Vacation	197,845.86
Insurance	0.00
Other	83,204.97
Due to third party payor	(1,489,005.02)
Income taxes:	
Current	0.00
Deferred	0.00
Total current liabilities	(274,321.48)
L-T debt, net of current portion:	
Notes, mortgages & conv. debt	0.00
Seller notes - LT	0.00
Subordinate debt	0.00
Credit facility debt	0.00
Capital leases	0.00
Other liabilities:	
Deferred income taxes	0.00
Other L-T liabilities	0.00
Total L-T debt & liab	0.00
Minority interest:	
Capital	0.00
Retained earnings	0.00
Total minority interest	0.00
Shareholders & partners equity:	
Common stock	0.00
Preferred stock (Class A)	0.00
Preferred stock (Class B)	0.00

COMPANY=422 (Memphis)

	CY2011
Preferred stock dividends	0.00
Distributions	0.00
Capital in excess of par	3,034,876.27
Retained earnings, prior	11,331,175.76
Current year net income (loss)	3,697,374.11
Total S & P equity	18,063,426.14
Total liabilities & equity	17,789,104.66

COMPANY=422 (Memphis)

	YTD ACTUAL 2011 Jan-Dec
CMI Medicare MTD	
CMI Medicare YTD	
Equivalent Patient Days	13,198.00
Average Daily Census	36.16
IP Physician Rounds	0.00
REVENUES	
Inpatient Routine	10,665,184.00
Inpatient Ancillary	44,700,483.47
Outpatient Ancillary	0.00
Total Patient Revenues	55,365,667.47
DEDUCTIONS FROM REVENUE	
Contractual Allowance	23,456,363.78
Contracted Discounts	10,670,361.59
Prior Year Contractual Adj	109,795.26
Other Revenue Deductions	18,339.10
Total Revenue Deductions	34,254,859.73
NET PATIENT REVENUE	21,110,807.74
Other Revenue	6,742.31
TOTAL NET REVENUE	21,117,550.05
OPERATING EXPENSES	
Salaries & Wages	7,338,941.56
Benefits	1,482,723.18
Contracted Departments	3,357,486.49
Physician Fees	146,606.00
Medical Supplies	2,303,936.51
Food & Other Supplies	123,051.65
Equipment Leases & Rentals	507,551.75
Other Fees	37,401.12
Data Processing Fees	0.00
Repairs & Maintenance	114,628.80
Utilities	32,564.21

COMPANY=422 (Memphis)

	YTD ACTUAL 2011 Jan-Dec
Insurance	114,612.00
Taxes, Non-Income	(9,499.99)
Other Expenses	225,356.82
Bad Debt Expenses	651,376.45
Corporate Services	267,180.38
Total Operating Expenses	16,693,916.93
NET OPERATING PROFIT	4,423,633.12
CONTRIBUTION MARGIN %	20.95%
CAPITAL COSTS	
Interest	0.00
Depreciation	79,239.36
Amortization	0.00
Facility/Office Lease	643,404.68
Property Taxes	20,001.00
Corporate Services Capital	469.87
Total Capital Costs	743,114.91
TOTAL COSTS	17,437,031.84
PRE-TAX/MGMT FEE	3,680,518.21
Management Fee	0.00
PRE-TAX/INTEREST	3,680,518.21
Intercompany Interest	(16,653.10)
Other Interest Income	(202.80)
PRE-TAX/MINORITY INT	3,697,374.11
Minority Interest	0.00
PRE-TAX PROFIT	3,697,374.11
Income Taxes	0.00
NET INCOME	3,697,374.11

COMPANY=422 (Memphis)

	YTD ACTUAL 2012 Jan-Oct
REVENUES	
Inpatient Routine	10,730,880.00
Inpatient Ancillary	38,409,511.40
Outpatient Ancillary	0.00
Total Patient Revenues	49,140,391.40
DEDUCTIONS FROM REVENUE	
Contractual Allowance	22,146,112.68
Contracted Discounts	9,162,123.41
Prior Year Contractual Adj	148,276.21
Other Revenue Deductions	70,040.80
Total Revenue Deductions	31,526,553.10
NET PATIENT REVENUE	17,613,838.30
Other Revenue	853.80
TOTAL NET REVENUE	17,614,692.10
OPERATING EXPENSES	
Salaries & Wages	6,550,500.46
Benefits	1,273,331.57
Contracted Departments	2,911,404.01
Physician Fees	124,028.00
Medical Supplies	1,875,330.03
Food & Other Supplies	119,020.81
Equipment Leases & Rentals	565,143.35
Other Fees	38,015.60
Data Processing Fees	0.00
Repairs & Maintenance	76,813.50

COMPANY=422 (Memphis)

	YTD ACTUAL 2012 Jan-Oct
Utilities	72,637.79
Insurance	97,294.80
Taxes, Non-Income	(6,100.63)
Other Expenses	232,617.33
Bad Debt Expenses	406,979.00
Corporate Services	262,937.17
Total Operating Expenses	14,599,952.79
NET OPERATING PROFIT	3,014,739.31
CONTRIBUTION MARGIN %	17.11%
CAPITAL COSTS	
Interest	0.00
Depreciation	54,303.09
Amortization	0.00
Facility/Office Lease	540,605.39
Property Taxes	16,064.55
Corporate Services Capital	0.00
Total Capital Costs	610,973.03
TOTAL COSTS	15,210,925.82
PRE-TAX/MGMT FEE	2,403,766.28
Management Fee	0.00
PRE-TAX/INTEREST	2,403,766.28
Intercompany Interest	(17,580.28)
Other Interest Income	(4.39)
PRE-TAX/MINORITY INT	2,421,350.95
Minority Interest	0.00
PRE-TAX PROFIT	2,421,350.95
Income Taxes	0.00
NET INCOME	2,421,350.95

Y YTD BALANCE SHEET REPORT

ORACLE Applications

lect Medical Corporation
od: OCT-12 Currency: USD
Submitted: 07-DEC-12 15:30:32

COMPANY=422 (Memphis)

	YTD 2012-Jan-Oct
Current assets:	
Cash and cash equivalents	0.00
Accounts receivables:	
Patient receivables	9,101,848.53
AR Clearing	(1,435,951.72)
Contractual adjustments	(4,523,218.76)
Allow for doubtful accounts	(685,939.78)
Other receivables	0.00
Prepaid expenses	0.00
Other current assets	145,124.39
Total current assets	2,601,862.66
Affiliates:	
Investments in	0.00
Advances to	14,814,575.74
Total affiliates	14,814,575.74
Property and equipment:	
Land	0.00
Building and improvements	754,831.67
Assets under capital leases	0.00
Furniture and equipment	1,248,912.96
Asset Clearing	0.00
Total fixed assets	2,003,744.63
Less accum. deprec	(1,761,722.64)
Net val property, plant & equip	242,021.99
Construction in progress	0.00
Total property, plant & equip	242,021.99
Other assets:	
Deposits	5,653.12
Prepaid rent	0.00
Goodwill, net	0.00
Other intangibles	0.00
Mgmt service agreements	0.00
Long term investments	0.00
Notes receivable	0.00
Deferred costs, net	0.00
Deferred financing costs, net	0.00
Other noncurrent assets	1,853.34
Total noncurrent assets	7,506.46
Total assets	17,665,966.85
Current liabilities:	
Notes payable	
Current portion of L-T debt:	
Seller notes - current	0.00
Notes and mortgages	0.00
Capital leases	0.00
Accounts payable	1,109,599.81
Accrued expenses:	
Payroll	0.00
Vacation	190,846.57
Insurance	0.00
Other	112,906.39
Due to third party payor	(1,825,872.01)
Income taxes:	
Current	0.00
Deferred	0.00
Total current liabilities	(412,519.24)
L-T debt, net of current portion:	
Notes, mortgages & conv. debt	0.00
Seller notes - LT	0.00
Subordinate debt	0.00
Credit facility debt	0.00
Capital leases	0.00
Other liabilities:	
Deferred income taxes	0.00
Other L-T liabilities	0.00
Total L-T debt & liab	0.00
Minority interest:	
Capital	0.00
Retained earnings	0.00
Total minority interest	0.00
Shareholders & partners equity:	
Common stock	0.00
Preferred stock (Class A)	0.00
Preferred stock (Class B)	0.00

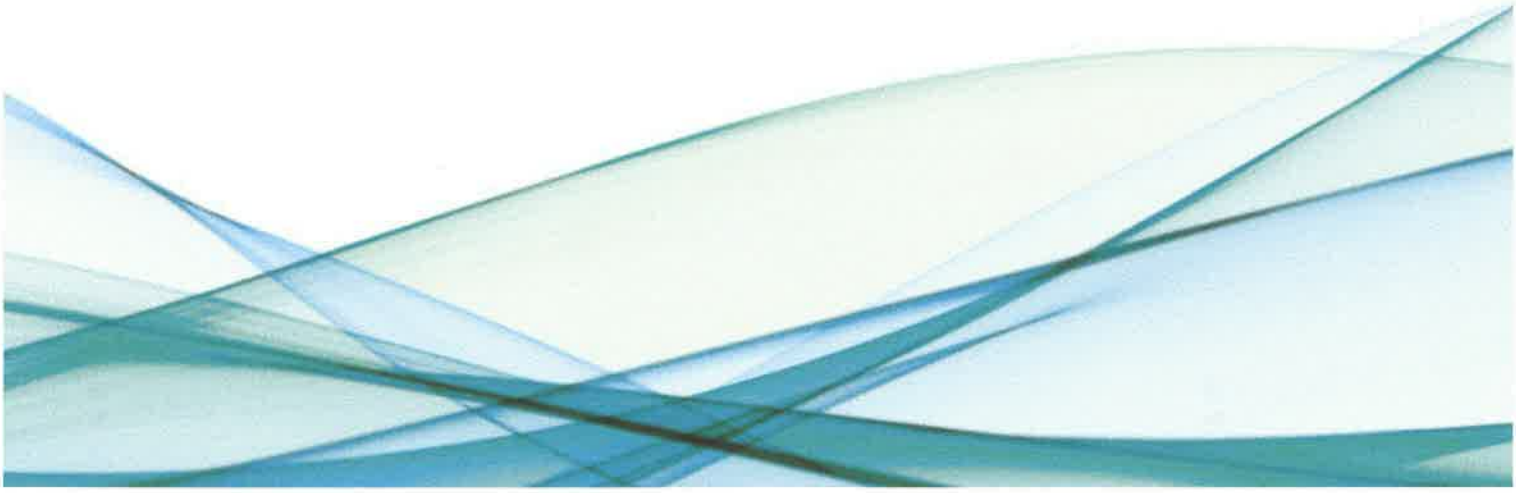
COMPANY=422 (Memphis)

	YTD 2012-Jan-Oct
Preferred stock dividends	0.00
Distributions	0.00
Capital in excess of par	3,034,876.27
Retained earnings, prior	12,622,258.87
Current year net income (loss)	2,421,350.95
Total S & P equity	18,078,486.09
Total liabilities & equity	17,665,966.85

SELECT MEDICAL HOLDINGS CORPORATION

2011 ANNUAL REPORT

Select MEDICAL
Improving Quality of Life



Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholder
of Select Medical Corporation:

In our opinion, the consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of Select Medical Corporation and its subsidiaries at December 31, 2011 and December 31, 2010, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2011 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedule, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedule, and on the Company's internal control over financial reporting based on our audits (which were integrated audits in 2011 and 2010). We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania
March 2, 2012

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders
of Select Medical Holdings Corporation:

In our opinion, the consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of Select Medical Holdings Corporation and its subsidiaries at December 31, 2011 and December 31, 2010, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2011 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedule, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedule, and on the Company's internal control over financial reporting based on our audits (which were integrated audits in 2011 and 2010). We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania
March 2, 2012

PART I *FINANCIAL INFORMATION*

ITEM 1. *CONSOLIDATED FINANCIAL STATEMENTS*

Consolidated Balance Sheets
(in thousands, except share and per share amounts)

	Select Medical Holdings Corporation		Select Medical Corporation	
	December 31, 2010	December 31, 2011	December 31, 2010	December 31, 2011
ASSETS				
Current Assets:				
Cash and cash equivalents	$ 4,365	$ 12,043	$ 4,365	$ 12,043
Accounts receivable, net of allowance for doubtful accounts of $44,416 and $47,469 in 2010 and 2011, respectively	353,432	413,743	353,432	413,743
Current deferred tax asset	30,654	18,305	30,654	18,305
Prepaid income taxes	12,699	9,497	12,699	9,497
Other current assets	28,176	29,822	28,176	29,822
Total Current Assets	429,326	483,410	429,326	483,410
Property and equipment, net	532,100	510,028	532,100	510,028
Goodwill	1,631,252	1,631,716	1,631,252	1,631,716
Other identifiable intangibles	80,119	72,123	80,119	72,123
Assets held for sale	11,342	2,742	11,342	2,742
Other assets	37,947	72,128	35,433	70,719
Total Assets	$2,722,086	$2,772,147	$2,719,572	$2,770,738
LIABILITIES AND EQUITY				
Current Liabilities:				
Bank overdrafts	$ 18,792	$ 16,609	$ 18,792	$ 16,609
Current portion of long-term debt and notes payable	149,379	10,848	149,379	10,848
Accounts payable	74,193	95,618	74,193	95,618
Accrued payroll	63,760	82,888	63,760	82,888
Accrued vacation	46,588	51,250	46,588	51,250
Accrued interest	30,937	15,096	21,586	11,980
Accrued restructuring	6,754	5,027	6,754	5,027
Accrued other	103,856	101,076	116,456	106,316
Due to third party payors	5,299	5,526	5,299	5,526
Total Current Liabilities	499,558	383,938	502,807	386,062
Long-term debt, net of current portion	1,281,390	1,385,950	974,913	1,218,650
Non-current deferred tax liability	59,074	82,028	59,074	82,028
Other non-current liabilities	66,650	64,905	66,650	64,905
Total Liabilities	1,906,672	1,916,821	1,603,444	1,751,645
Stockholders' Equity:				
Common stock of Holdings, $0.001 par value, 700,000,000 shares authorized, 154,519,025 shares and 145,268,190 shares issued and outstanding in 2010 and 2011, respectively	155	145	—	—
Common stock of Select, $0.01par value, 100 shares issued and outstanding	—	—	0	0
Capital in excess of par	535,628	493,828	834,894	848,844
Retained earnings	248,097	328,882	249,700	137,778
Total Select Medical Holdings Corporation and Select Medical Corporation Stockholders' Equity	783,880	822,855	1,084,594	986,622
Non-controlling interest	31,534	32,471	31,534	32,471
Total Equity	815,414	855,326	1,116,128	1,019,093
Total Liabilities and Equity	$2,722,086	$2,772,147	$2,719,572	$2,770,738

The accompanying notes are an integral part of these consolidated financial statements.

Select Medical Holdings Corporation

Consolidated Statements of Operations
(in thousands, except per share amounts)

	For the Year Ended December 31,		
	2009	2010	2011
Net operating revenues	$2,239,871	$2,390,290	$2,804,507
Costs and expenses:			
Cost of services	1,819,771	1,982,179	2,308,570
General and administrative	72,409	62,121	62,354
Bad debt expense	40,872	41,147	51,347
Depreciation and amortization	70,981	68,706	71,517
Total costs and expenses	2,004,033	2,154,153	2,493,788
Income from operations	235,838	236,137	310,719
Other income and expense:			
Gain (loss) on early retirement of debt	13,575	—	(31,018)
Equity in earnings (losses) of unconsolidated subsidiaries	—	(440)	2,923
Other income (expense)	(632)	632	—
Interest income	92	—	322
Interest expense	(132,469)	(112,337)	(99,216)
Income before income taxes	116,404	123,992	183,730
Income tax expense	37,516	41,628	70,968
Net income	78,888	82,364	112,762
Less: Net income attributable to non-controlling interests	3,606	4,720	4,916
Net income attributable to Select Medical Holdings Corporation	75,282	77,644	107,846
Less: Preferred dividends	19,537	—	—
Net income available to common stockholders and participating securities	$ 55,745	$ 77,644	$ 107,846
Income per common share:			
Basic	$ 0.61	$ 0.49	$ 0.71
Diluted	$ 0.61	$ 0.48	$ 0.71

The accompanying notes are an integral part of these consolidated financial statements.

Select Medical Corporation

Consolidated Statements of Operations
(in thousands)

	For the Year Ended December 31,		
	2009	**2010**	**2011**
Net operating revenues	$2,239,871	$2,390,290	$2,804,507
Costs and expenses:			
Cost of services	1,819,771	1,982,179	2,308,570
General and administrative	72,409	62,121	62,354
Bad debt expense	40,872	41,147	51,347
Depreciation and amortization	70,981	68,706	71,517
Total costs and expenses	2,004,033	2,154,153	2,493,788
Income from operations	235,838	236,137	310,719
Other income and expense:			
Gain (loss) on early retirement of debt	12,446	—	(20,385)
Equity in earnings (losses) of unconsolidated subsidiaries	—	(440)	2,923
Other income	3,204	632	—
Interest income	92	—	322
Interest expense	(99,543)	(84,472)	(81,232)
Income before income taxes	152,037	151,857	212,347
Income tax expense	49,987	51,380	80,984
Net income	102,050	100,477	131,363
Less: Net income attributable to non-controlling interests	3,606	4,720	4,916
Net income attributable to Select Medical Corporation	$ 98,444	$ 95,757	$ 126,447

The accompanying notes are an integral part of these consolidated financial statements.

C, Orderly Development--7(C)
TDH Inspection & Plan of Correction

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

June 2, 2006

Mr. Jeff Fee, Administrator
Parkridge Medical Center
2333McCallie Avenue
Chattanooga TN 37404

Dear Administrator:

Enclosed is a Statement of Deficiencies which was developed as the result of the state licensure survey conducted at your facility on May 23 and 24, 2006. Corrective action must be achieved **prior to** July 9, 2006, the forty-fifth (45th) day from the date of survey. A revisit may be conducted to verify compliance.

Please develop a Plan of Correction for the deficiencies cited and return within ten (10) calendar days after receipt of this letter to:

Bureau of Health Licensure and Regulation
Lakeshore Park, Building 1
5904 Lyons View Pike
Knoxville, TN 37919

Your POC must contain the following:

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficiency practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

If you have any questions, please contact this office at (865) 588-5656.

Sincerely,

Faye Vance/ mad

Faye Vance, R.N., B.S., M.S.N.
Public Health Nurse Consultant Manager

FV:afl

Enclosure: 2567

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-1 Initial This Statute is not met as evidenced by: An onsite licensure survey was conducted from May 22, 2006 through May 24, 2006, at the three facilities included within the Parkridge Medical Center, Inc. From purposes of clarification, in this Statement of Deficiency, Parkridge Medical Center on McCallie Avenue will be referred to as Hospital A. Parkridge East Hospital will be referred to as Hospital B and Parkridge Valley Hospital will be referred to as Hospital C. An entrance conference was conducted at Hospital A at 10:00 a.m., on May 22, 2006, with the Chief Nursing Executive, the Associate Nursing Officer, the Vice President of Quality, and the Vice President of Education. An entrance conference was conducted at Hospital B at 10:00 a.m., May 22, 2006, with the Chief Executive Officer and the Chief Nursing Officer. An entrance conference was conducted at Hospital C at 8:00 a.m., on May 23, 2006, with the Chief Nursing Executive, Director of Adult Services, Director of Child and Adolescent Services, and Director of Quality and Risk Management. An exit conference pertaining to all 3 facilities surveyed was provided at Hospital A on May 24, 2006, at 1:45 p.m., with the Chief Nursing Executive and several additional administrative staff members in attendance. Survey findings were shared and questions were answered.	H 001		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 681	Continued From page 1	H 681		
H 681	1200-8-1-.06 (4)(j) Basic Hospital Functions (4) Nursing Services. (j) All drugs, devices and related materials must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures This Statute is not met as evidenced by: Facility B Based on observation, medical record review, and interview, the facility failed to assure a physician's order was carried out for one (#7) of ten residents sampled. The findings included: Medical record review revealed the patient was admitted on May 22, 2006, with diagnosis including Urinary Tract Infection. Medical record review revealed a Physician's Order dated May 22, 2006, at 9:48 a.m., "...D/C (discontinue) (named) catheter (system to drain urine)..." Observation of the patient on May 23, 2006, at 2:00 p.m., revealed the patient lying in bed with a catheter in place. Interview with the Manager of the Medical Surgical Unit on May 23, 2006, at 2:00 p.m., confirmed the order to discontinue the catheter had not been carried out. Based on observation and interview, the facility failed to ensure medications had not expired for the emergency department's pediatric crash cart.	H 681		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 681	Continued From page 2 The findings included: Observation of the pediatric crash cart in the emergency room on May 23, 2006, at 10:30 a.m., revealed the following drugs had expired: 1. 2 vials of Aminophylline expired 4-1-06 2. 2 vials of Calcium Gluconate expired 2-06 3. 2 Dextrose pediatric syringes expired 4-1-04 4. 6 Sodium Bicarbonate pediatric syringes expired 5-1-06 5. 2 vials of Adenocard expired 3-06. Interview with the Director of the Emergency Department at the time of discovery confirmed the facility failed to ensure medications for the pediatric crash cart had not expired.	H 681		
H1031	1200-8-1-.10 (11) Infectious Waste and Hazardous Waste (11)All garbage, trash and other non-infectious waste shall be stored, transported, and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, constructed of easily-cleanable material and shall be kept on elevated platforms. Authority: T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209 and 68-11-216. This Statute is not met as evidenced by: Facility B Based on observation and interview, the facility failed store garbage in a manner to prevent transmission of disease and prohibit a breeding place for insects and rodents for one of one trash compactor.	H1031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

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H1031	Continued From page 3 The findings included: Observation and interview with the Supervisor of the Dietary Department on May 22, 2006, at 1:00 p.m., revealed the open area of the trash compactor for depositing trash to be compacted contained numerous large garbage bags filled with trash. Several of the bags had a white liquid on the outside of the bags. Two of the bags were punctured. The supervisor confirmed the trash had not been compacted and the trash was not to be left exposed.	H1031		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 01 - PARKRIDGE MEDICAL CE B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Statute is not met as evidenced by: Based on observation, the facility failed to assure the corridors in the means of egress were maintained clear of all obstructions (NFPA 101-7.1.10.2.1.) The findings include: Observation on May 22 and 23, 2006 between 8:00 a.m. and 5:00 p.m. revealed the 1st floor rear corridor had three (3) beds and eight (8) clean linen bins along the entire length of the corridor. Observation on May 22, 2006 at 4:30 p.m. and May 23, 2006 between 8:00 a.m. and 9:30 a.m. revealed the rear fire exit by the outdoor Oxygen storage area was blocked by carts. Observation on May 22, 2006 at 10:30 a.m. revealed the main 2nd floor rear corridor had two (2) beds, two (2) MRI dollies, and two (2) portable X-ray machines in the corridor. Observation on May 22, 2006 at 11:30 a.m. revealed the radiology corridor had six (6) chairs in the corridor, seven (7) empty portable oxygen carriers, an IV pole, and a 2-drawer cabinet. Based on observation, the facility failed to assure smoke detectors were located at least 3 feet from	H 871		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 01 - PARKRIDGE MEDICAL CE B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	Continued From page 1 an air supply (NFPA 72, 2-3.5.1). The findings include: Observation on May 22, 2006 at 2:35 p.m. revealed the smoke detectors on the 1st floor corridor outside the Materials Management rear entrance was one (1) foot from an air supply. Observation on May 22, 2006 at 2:50 p.m. revealed the smoke detectors on the 2nd floor corridor at the elevator lobby was one (1) foot from an air supply. Observation on May 22, 2006 at 4:50 p.m. revealed the A and D first floor elevators were not provided with smoke detectors at their rear lobby area. Based on observation, the facility failed to assure hazardous area one (2) hour fire rated construction is maintained. The findings include: Observation on May 23, 2006 at 2:00 p.m. revealed the 1st floor mechanical room (old generator room) had a 2-hour rated wall with an unsealed chiller box in the corridor wall. Maintenance personnel indicated this is no longer being used.	H 871		
H 872	1200-8-1-.08 (2) Building Standards (2) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.	H 872		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 01 - PARKRIDGE MEDICAL CE B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 872	Continued From page 2 This Statute is not met as evidenced by: Based on observation, the facility failed to assure oxygen bottles are secured and No Smoking signs were provided in areas where oxygen is used or stored (NFPA 99, 8.6.4.2). The findings include: Observation on May 22, 2006 between 8:00 a.m. and 4:30 p.m. revealed the following areas have unsecured oxygen bottles, and no signs in place stating "No Smoking oxygen in use" where oxygen is stored or in use: 1. Fifth floor soiled utility. 2. Fifth floor respiratory therapy room. 3. Loading dock oxygen storage area. 4. Four west oxygen storage room. 5. Cardiac recovery unit. 6. MICU storage room.	H 872		
H 893	1200-8-1-.08 (23) Building Standards. (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Statute is not met as evidenced by: Based on observation, the facility failed to assure soiled linen storage areas were well ventilated and maintained under a relative negative air pressure. The findings include:	H 893		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 01 - PARKRIDGE MEDICAL CE B. WING	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 893	Continued From page 3 Observation on May 23, 2006 at 10:30 a.m. revealed the surgery soiled utility room has no negative air pressure.	H 893		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 02 - EASTRIDGE B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Statute is not met as evidenced by: Based on observation, the facility failed to assure smoke detectors were located at least 3 feet from an air supply (NFPA 72, 2-3.5.1). The findings include: Observation on May 22, 2006 at 10:15 a.m. revealed the smoke detectors at the 2W nurses station, 1st floor L&D clean linen room, and day surgery were located (1) foot from an air supply. Based on observation, the facility failed to assure the sprinkler system was maintained and sprinkler piping was not used to support non-system components. (NFPA 13, 9-1.1.7) The findings include: Observation on May 22, 2006 at 1:30 p.m. revealed the 1st floor mechanical room had low voltage wiring supported by and tie wrapped to sprinkler piping.	H 871		

The Joint Commission
Summary of Findings

DIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.07	EP6
	IC.02.02.01	EP2
	LS.02.01.20	EP1
	MM.04.01.01	EP13
	PC.01.02.01	EP23
	PC.02.01.03	EP1
	PC.03.01.03	EP1

INDIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.09	EP3
	LD.04.01.05	EP4
	LS.02.01.30	EP11
	MM.03.01.01	EP2
	MS.03.01.03	EP2
	MS.06.01.03	EP1
	PI.03.01.01	EP4
	RC.01.01.01	EP19
	RC.01.02.01	EP3
	RC.02.03.07	EP4
Program:	Behavioral Health Care Accreditation Program	
Standards:	CTS.05.05.07	EP2

CoP: §482.21 **Tag:** A-0263 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.21 Condition of Participation: Quality Assessment and Performance Improvement Program

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

CoP Standard	Tag	Corresponds to	Deficiency
§482.21(a)(1)	A-0265	HAP - PI.03.01.01/EP4	Standard

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.08.01.03/EP1	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(2)	A-0406	HAP - RC.02.03.07/EP4	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.02.01/EP3, RC.01.01.01/EP19	Standard
§482.24(c)(1)(iii)	A-0457	HAP - RC.02.03.07/EP4	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.05.07/EP6	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP1, LS.02.01.30/EP11	Standard

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)	A-0951	HAP - IC.02.02.01/EP2	Standard

CoP: §482.57 **Tag:** A-1151 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.57 Condition of Participation: Respiratory Care Services

The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care services.

CoP Standard	Tag	Corresponds to	Deficiency
§482.57(b)(3)	A-1163	HAP - PC.02.01.03/EP1	Standard

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.07

Standard Text: The hospital inspects, tests, and maintains emergency power systems.
Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

6. Twelve times a year, at intervals of not less than 20 days and not more than 40 days, the hospital tests all automatic transfer switches. The completion date of the tests is documented.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During the document review of the two generators at the Parkridge Medical Center, it was noted that the 10 automatic transfer switches were tested on July 22, 2010 and then on August 5, 2010. The testing was not conducted within the 20 and 40 day period.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.09

Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems.
Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in Building Tour at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
This was observed but corrected on site. During the building tour of the Parkridge Medical Center, it was observed on the 5th floor in the Cardiopulmonary Department that the patient rooms were not identified. As a result, the signage that was placed on the medical gas valves for oxygen, medical air and vacuum did not accurately reflect the rooms that were served by the system.

Observed in Building Tour at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
This was observed but corrected on site. During the building tour of the Parkridge Medical Center, it was observed on the 2nd floor near the Cardiac Recovery Unit that a medical gas shut-off valve had not been correctly labeled. The labeled stated "CP Ctr, EKG, PFT, CIUty.." but the area had been renovated and the rooms had different identifiers. It could not be determined which rooms were controlled by the valves at the time of survey.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Intermediate-level disinfection is used for items such as specula. Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/ncidod/dhqp/sterile.html (Sterilization and Disinfection in Healthcare Settings).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
In the GI Lab after a case is completed, the colonoscopy and/or endoscopy scopes are carried in a covered tray from the procedure room to the room where they are cleaned and the high level disinfection is done. After this they are put on a fresh tray and in an uncovered fashion brought through the same door and pathway that the dirty scopes followed, and then they are hung in a storage cabinet in the hallway. It was recommended that after the high level disinfection the scopes be carried to the storage cabinet in a covered fashion, and if possible not follow any of the path used by the dirty scopes.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.01.05

Standard Text: The hospital effectively manages its programs, services, sites, or departments.

Primary Priority Focus Area: Staffing

Element(s) of Performance:

4. Staff are held accountable for their responsibilities.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During individual patient tracer in the Gero Psychiatric unit, it was identified that only nursing staff work on weekends and the program activities are being completed by the registered nurses. During the week, the program activities are being held by an activity therapist and a social worker. In discussion with the staff, it was identified that a specific competency had not been developed or implemented for the registered nurses completing the program activities . In addition, during discussion with staff, it was identified that leadership had not developed guides, course outlines or evaluations for the program activities that were being provided to the patients.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. Doors in a means of egress are unlocked in the direction of egress. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

The Joint Commission
Findings

EP 1
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
Observed but corrected on site. During the building tour of the Parkridge East Hospital, it was observed in the Labor and Delivery unit on the 1st floor that a pair of smoke barrier doors had magnetic locks installed on the frame. According to staff, upon activation of the fire alarm, the doors would remain locked for 15 seconds and then release. There was no signage on the door to indicate the delayed activity of the door to the occupants of the unit.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.
Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 11
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center, it was observed on the 5th floor in the Cardiopulmonary Department, that a corridor door had been prevented from closing because a patient bed had been placed in front of it. The room was being used to store beds and this bed stuck out of the room thus preventing the door from closing. This was also observed for another room in the department. The rooms were not identified by any signage.

Observed in Building Tour at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During the building tour of the Parkridge East Hospital, it was observed on the 2nd floor East, that the ICU doors on the east-side had a gap at the meeting edges of the corridor doors had a gap of approximately ¾-inch.

Observed in Building Tour at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During the building tour of the Parkridge East Hospital, it was observed on the 2nd floor East, that the ICU doors on the west-side had a gap at the meeting edges of the corridor doors had a gap of approximately ¾-inch.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.03.01.03

Standard Text: The management and coordination of each patient's care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

2. The hospital educates all licensed independent practitioners on assessing and managing pain. (See also RI.01.01.01, EP 8)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site.
During individual patient tracer and review of newborn records, it was identified that circumcision surgical procedure had been completed on a newborn without any management of pain pre, during and post procedure. In discussion with leadership, it was identified that most physicians credentialed to perform the circumcision procedure had not been addressing the problem of pain management during any portion of the process of the circumcision.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.08.01.03

Standard Text: Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

1. The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.
This Standard is NOT MET as evidenced by:
Observed in the Credentialing Session at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
Credentialing files of a pathologist and radiologist revealed that the physician profiles that the HCO used were generic and did not have appropriate benchmarks for these two specialties. The HCO has started to implement new profiles which have metrics germane to all of the specific specialties represented at the hospital.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.03.01.01

Standard Text: The hospital safely stores medications.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

2. The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 2
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
In the Surgical Cath Lab Isovue is kept in a warmer, however the manufacturer recommends that the contrast media be kept at a temperature of 20 - 25 degrees C.

Observed in individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
While visiting the Interventional Imaging Lab it was noted that Isovue was kept in a warmer at temperatures of 34 to 37 degrees C, and expiration dates were not changed once the medication was placed in the warmer. It was recommended that this particular agent be kept at room temperatures, and if the HCO wanted to use a warmed contrast agent, they choose one that is approved for this type of storage by the manufacturer. During the survey the HCO decided to discontinue the use of the warmer in both locations.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.04.01.01

Standard Text: Medication orders are clear and accurate.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

13. The hospital implements its policies for medication orders. 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 13
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During individual patient tracer, record # 1 contained orders for medication to be administered either PO or IV without guidelines for the nurse to utilize for administration.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During individual patient tracer, record # 2 contained multiple medications for the same complaint without written guidelines for the nurse to utilize for administration.

Chapter: Performance Improvement

Program: Hospital Accreditation

Standard: PI.03.01.01

Standard Text: The hospital improves performance on an ongoing basis.

Primary Priority Focus Area: Quality Improvement Expertise/Activities

Element(s) of Performance:

4. The hospital takes action when it does not achieve or sustain planned improvements. (See also MS.05.01.01, EPs 1-11)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.21(a)(1) - (A-0265) - (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and...
This Standard is NOT MET as evidenced by:
Observed in D at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During review of documents provided by the organization, it was identified that a decrease utilization of restraints in the facility had not been sustained over the past 12 months. Example:restraints per patient day for the 4th quarter of 2009 was 348.45 restraints per/1000 patient days and in 4th quarter of 2011 the level had increased to 549.53 restraints per/1000 patient days. In addition, falls for the 3rd quarter of 2009 were 3.73 and remained constant or increased over the past 12 months to 3.99 for the 1st quarter of 2011.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.01

Standard Text: The hospital assesses and reassesses its patients.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

23. During patient assessments and reassessments, the hospital gathers the data and information it requires.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 23
Observed in Individual Tracer at Parkridge Valley Hospital (2200 Morris Hill Road, Chattanooga, TN) site.
The record of a pediatric patient who had been admitted to the acute psychiatric hospital was reviewed. The initial nursing assessment was incomplete because there was no documentation of a comprehensive pain assessment which was required by policy on all admissions.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site.
The clinical record of a patient who had undergone a general surgical procedure the previous day was reviewed. There was an admission note, a history and physical examination, an immediate post procedure progress note, and a subsequent daily progress note for the first postoperative day. All notes were complete. However, all notes had been written by a surgical resident. There was no independent note by the attending surgeon, and there was no authentication signature from the attending surgeon on any of the resident's notes to indicate review and concurrence with the findings. Medical staff rules and regulations required authentication of residents' notes by the responsible supervising physician.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
Four clinical records for patients who had come for ECT treatments were reviewed. The hospital was using a form to document both the anesthesiologist's preanesthesia assessment and the physician's H&P. The physician's H&P on each record was incomplete because there was no documentation of assessment of the heart and lungs as required for short stay patients by medical staff rules and regulations.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.03

Standard Text: The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner in accordance with professional standards of practice and law and regulation. *
Footnote *: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.57(b)(3) - (A-1163) - (3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During individual patient tracer, it was identified that physicians performing operative procedure did not complete post procedure orders for the continuation of care. This was noted on the post partum unit during the review of circumcised newborn charts.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.01.03

Standard Text: The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. (See also RC.02.01.01, EP 2)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
The record of a patient who had undergone a cardiac catheterization procedure utilizing moderate sedation was reviewed. The documentation of the preanesthesia risk assessment by the cardiologist was incomplete. The form included spaces to document physical examination of the heart and lungs, but these portions of the form had been left blank. There was documentation of an assessment of the upper airway (Malampati score) and a numerical designation for the ASA score.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
The record of a second patient who had undergone a cardiac catheterization under moderate sedation was reviewed. The documentation of the preanesthesia risk assessment was not complete because the areas for documentation of a physical examination of the heart and lungs had not been filled in by the cardiologist.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site.
The record of a patient who had just undergone an orthopedic surgical procedure under general anesthesia was reviewed. The preanesthesia risk assessment had not been documented by the anesthesiologist. There was a signature, date and time at the bottom of the assessment form, but the remainder of the form was completely blank. The anesthesiologist discussed the issue with the surveyor and made a "late entry" note in the record to complete the form.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Intensive Outpatient Program (2775 Executive Park, Cleveland, TN) site for the Hospital deemed service.
During individual patient tracer, record # 1 contained multiple authentications by the physician that did not contain either a date and time as per facility policy and procedure.

Observed in Individual Tracer at Intensive Outpatient Program (2775 Executive Park, Cleveland, TN) site for the Hospital deemed service.
During individual patient tracer, record # 2 contained multiple authentications by the physician that did not contain a date or time as per facility policy and procedure.

Observed in Individual Tracer at Intensive Outpatient Program (2775 Executive Park, Cleveland, TN) site for the Hospital deemed service.
During individual patient tracer, record # 3 contained multiple authentications by the physician that did not contain a date or time as per facility policy and procedure.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During individual patient tracer, record # 4 contained multiple authentications by the physician that had not been dated or timed as per facility policy and procedure.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During individual patient tracer, record #5 contained multiple authentications by the physician that had not been dated or timed as per facility policy and procedure.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.02.01

Standard Text: Entries in the medical record are authenticated.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

3. The author of each medical record entry is identified in the medical record.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 3
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in The Radiation Oncology Unit Visit at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
In the Radiation Oncology Unit the chart of a patient with breast cancer was reviewed. A multi-page entry consisting of the patient's history contained three different handwritings, however there were no signatures denoting who made the entries.

Observed in The Radiation Oncology Unit at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
In the Radiation Oncology Unit the chart of a patient with prostate cancer was reviewed and a similar finding was noted with respect to the missing attestation of authorship.

Observed in Individual Tracer at Parkridge Valley Hospital (2200 Morris Hill Road, Chattanooga, TN) site for the Hospital deemed service.
The record of a pediatric patient who had been admitted to the acute psychiatric unit was reviewed. The psychiatric admission history and physical examination was a hand written document. The handwriting in one area of the form, which documented historical information, was different than in the remainder of the form. It was learned that the psychiatric social worker had interviewed the patient and entered information for the physician. However, the author of that portion of the medical record was not identified by name, and the date and time of that record entry was not documented. There was a physician's signature at the end of the form, but the physician had not indicated his review and validation of the information entered by the other staff member.

Observed in Individual Tracer at Parkridge Valley Hospital (2200 Morris Hill Road, Chattanooga, TN) site for the Hospital deemed service.
In a psychiatrist's evaluation of a patient, it was observed that additional information had been added by a social services professional, who did not note his/her name or the date of entry.

Chapter:	Record of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	RC.02.03.07
Standard Text:	Qualified staff receive and record verbal orders.
Primary Priority Focus Area:	Information Management

Element(s) of Performance:

4. Verbal orders are authenticated within the time frame specified by law and regulation. 
Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: If there is no state law that designates a specific time frame for authentication of verbal orders, the verbal orders are authenticated within 48 hours.
Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: In some instances, the ordering practitioner may not be able to authenticate his or her verbal order (for example, the ordering practitioner gives a verbal order that is written and transcribed, and then he or she is 'off duty' for the weekend or an extended period of time). In such cases, for a temporary period expiring on January 26, 2012, it is acceptable for another practitioner who is responsible for the patient's care to authenticate the verbal order of the ordering practitioner.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 4
§482.23(c)(2) - (A-0406) - (2) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c).
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The record of a patient who had been admitted with a positive MRSA screening test was reviewed. The patient was to undergo an operative procedure, and vancomycin was ordered preoperatively. The order was transcribed as "noted" by a nurse on 6/7/11. There was no attestation as to whether this was a verbal order or a telephone order. The patient received the medication on 6/10/11. No physician had authenticated the order as of 6/13/11, the day on which the record was reviewed. Medical staff rules and regulations required authentication of verbal and telephone orders within 48 hours.

§482.24(c)(1)(iii) - (A-0457) - (iii) All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The record of a patient been admitted with a myocardial infarction and had undergone a cardiac catheterization procedure was reviewed. The record contained two separate verbal orders which had been transcribed on 6/10/11. They had not been authenticated by the physician as of 6/13/11, the day of review. Medical staff rules and regulations required authentication of verbal and telephone orders within 48 hours.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
In the record of a patient who had undergone a cardiac surgical procedure there were two verbal or telephone orders written at 1800 hours and at 2040 hours on 6/10/11. These orders had not been authenticated by the physician within 48 hours as required by medical staff rules and regulations

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During individual patient tracer, record # 1 contained multiple telephone orders that had not been authenticated within the 48 hours as per facility facility policy and procedure.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During individual patient tracer, record # 2 contained multiple telephone orders that had not been authenticated within the 48 hours as per facility facility policy and procedure.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During individual patient tracer, record #3 contained telephone orders that had been signed but had not been dated and timed as per facility policy and procedure.

Chapter:	Care, Treatment, and Services
Program:	Behavioral Health Care Accreditation
Standard:	CTS.05.05.07

The Joint Commission
Findings

Standard Text: For organizations that use physical holding on a child or youth: The initial assessment and reassessments of each child or youth assists the organization in obtaining information about the child or youth that could help minimize the use and impact of physical holding.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

2. For organizations that use physical holding on a child or youth: The initial assessment and reassessments of a child or youth identify pre-existing medical conditions or any physical disabilities and limitations that would place the child or youth at greater risk during a physical hold.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 2
Observed in Individual Tracer at Parkridge Valley Hospital (2200 Morris Hill Road, Chattanooga, TN) site.
In a record of a youth who was restrained, there was no indication that the youth's medical condition (asthma) had been identified during the assessment as a potential risk if restraint were to be used.

Observed in Individual Tracer at Parkridge Valley Hospital (2200 Morris Hill Road, Chattanooga, TN) site.
In a second record of a youth who had been restrained, there was no indication that an orthopedic injury he had recently sustained was identified as a potential risk if restraint were to be used.

AFFIDAVIT

STATE OF TENNESSEE)
)
COUNTY OF HAMILTON)

Re: Parkridge Medical Center

Jay St. Pierre, being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Agency Rules, and T.C.A. ' 68-11-1601, et seq., and that the responses to questions in this application or any other questions deemed appropriate by the Tennessee Health Services and Development Agency are true and complete.

Name

Chief Financial Officer
Title

Sworn to and subscribed before me this the 13 day of February, 2012 a Notary Public in and for Hamilton County, Tennessee.

Samantha Vandergriff
Notary Public

My Commission Expires: 6/16/15.

SAMANTHA VANDERGRIFF
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Miscellaneous Information

Select Specialty Hospitals in Tennessee

Select Specialty Hospital--Memphis
5959 Park Avenue (12th Floor)
Memphis, TN 38119

Select Specialty Hospital--Nashville
2000 Hayes Street, Suite 1502
Nashville, TN 37203

Select Specialty Hospital--Knoxville
1901 Clinch Avenue (4th Floor)
Knoxville, TN 37916

Select Specialty Hospital--North Knoxville
900 East Oak Hill Avenue (4th Floor)
Knoxville, TN 37917

Select Specialty Hospital--Tricities
One Medical Park Boulevard (5th Floor West)
Bristol, TN 37620

Moratorium — See pp 4-5

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Details for: FINAL POLICY AND PAYMENT CHANGES FOR INPATIENT STAYS IN ACUTE-CARE HOSPITALS

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For Immediate Release: Wednesday, August 01, 2012

Contact: CMS Media Relations
202-690-6145

FINAL POLICY AND PAYMENT CHANGES FOR INPATIENT STAYS IN ACUTE-CARE HOSPITALS AND LONG-TERM CARE HOSPITALS IN FY 2013

OVERVIEW: On August 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that will update Medicare payment policies and rates for inpatient stays in acute-care hospitals under the Inpatient Prospective Payment System (IPPS) and hospitals paid under the Long-Term Care Hospitals (LTCH) Prospective Payment System (PPS), in fiscal year (FY) 2013. The rule also finalizes the payment update that will be used to calculate FY 2013 target amounts for certain hospitals excluded from the IPPS, such as cancer and children's hospitals, and religious nonmedical health care institutions.

The rule, which will apply to approximately 3,400 acute-care hospitals and approximately 440 LTCHs, will generally be effective for discharges occurring on or after October 1, 2012. Under the rule, payment rates for inpatient stays in general acute-care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program will be increased by 2.8 percent. Those that do not successfully participate in the IQR Program will receive an increase of 0.8 percent (i.e., a 2.0 percentage point reduction). CMS projects that the rate increase—together with other policies established in the rule, the expiration of certain statutory provisions that provided special temporary increases in payments to hospitals, and other changes to the IPPS payment policy—will increase payments by about $2 billion in FY 2013, or 2.3 percent.

Medicare payments to LTCHs in FY 2013 are projected to increase by approximately $92 million or 1.7 percent. Provisions affecting LTCHs are described in more detail below in this fact sheet.

This fact sheet discusses major payment provisions of the final rule. A separate fact sheet on policies relating to the provision of high-quality care is available on the CMS web page at:

www.cms.gov/apps/media/fact_sheets.asp.

BACKGROUND: By law, CMS pays acute-care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. These prospective payment systems set rates prospectively based on the patient's diagnosis and the severity of the patient's medical condition. Under the IPPS and

the LTCH PPS, a hospital receives a single payment for the case based on the payment classification assigned at discharge: "MS-DRGs" under the IPPS and "MS-LTC-DRGs" under the LTCH PPS. Medicare law requires CMS to update the payment rates for IPPS hospitals annually to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients—known as the hospital "market basket"—as well as for other factors. Critical Access Hospitals (CAHs), children's hospitals, certain cancer hospitals, and certain other facilities do not receive payments under the IPPS.

Until FY 2008, discharges from acute-care hospitals were classified into one of 538 CMS-diagnosis-related groups (DRGs). In FY 2008, CMS replaced the 538 DRGs with 745 MS-DRGs that provide higher payments for more severely ill or injured patients and lower payments for all other cases. Since FY 2008, CMS has modified these MS-DRGs through notice and comment rulemaking, bringing the current total number of MS-DRGs to 751.

The LTCH PPS was implemented in FY 2003. Medicare payments under the LTCH PPS are based on the same DRG system as the IPPS, but payment weights associated with the LTCH patient classifications are calculated based on generally higher treatment costs at LTCHs. In conjunction with the IPPS, the LTCH PPS adopted MS-LTC-DRGs in FY 2008.

POLICIES AFFECTING ACUTE-CARE HOSPITALS

Changes to Payment Rates under IPPS: The rule will increase IPPS operating payment rates by 2.8 percent. This reflects an update of 2.6 percent for the hospital market basket adjusted by a multi-factor productivity adjustment of -0.7 percentage point and an additional -0.1 percentage point in accordance with the Affordable Care Act; this is increased by 1.0 percent for documentation and coding adjustments (more detail about these adjustments is included later in this fact sheet).

Policies to Continue Implementing the Affordable Care Act:

Hospital Readmissions Reduction Program: Section 1886(q) of the Social Security Act, as added by section 3025 of the Affordable Care Act, establishes the Hospital Readmissions Reduction

Program, which requires CMS to reduce payments to certain hospitals with excess readmissions, effective for discharges beginning on or after October 1, 2012.

In the FY 2012 IPPS/LTCH PPS final rule, CMS began implementation of the Readmissions Reduction Program and finalized the following policies:

- The use of three 30-day readmission measures---Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN), endorsed by the National Quality Forum for FY 2013 and FY 2014;

- The definition of "readmission" as generally referring to an admission to an acute-care hospital paid under the IPPS within 30 days of a discharge from the same or another acute-care hospital (subject to technical issues addressed in the rule);

- The calculation of a hospital's excess readmission ratio for AMI, HF and PN, which is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition; and

- A policy to use three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio for each applicable condition. In FY 2013, the excess readmission ratio will be based on discharges occurring during the 3-year period of July 1, 2008 to June 30, 2011.

The FY 2013 IPPS/LTCH PPS Rule finalizes a methodology to calculate the readmissions adjustment factor, which is the higher of a ratio of a hospital's aggregate dollars for excess readmissions to their aggregate dollars for all discharges, or 0.99 (i.e., a 1.0 percent reduction) for FY 2013. CMS will apply the readmission adjustment factor to a hospital's base operating DRG payment amount and estimates that the Hospital Readmissions Reduction Program will result in a 0.3 percent, or approximately $270 million decrease in overall payments to hospitals.

Hospital Value-Based Purchasing (VBP) Program: The final rule addresses operational details relating to payment rates to hospitals in FY 2013 (the first year that the VBP program's payment implications will go into effect), as well as additional measures and policies that will affect value-based incentive payments for hospitals in FY 2015 and FY 2016.

For additional information about the Hospital VBP Program policies in this rule, please see the fact sheet on quality issues at: www.cms.gov/apps/media/fact_sheets.asp.

Documentation and Coding Adjustment:

The final rule will complete all documentation and coding adjustments for FY 2008 and FY 2009 as required by the TMA, Abstinence Education, and QI Programs Extension Act of 2007.

Below is a summary of documentation and coding adjustments that will affect the FY 2013 IPPS update:

Remaining FY 2008 and FY 2009 Prospective Documentation and Coding Adjustment	-1.9 percent
Restoration of One-Time 2012 Recoupment Adjustment	+2.9 percent
Total	+1.0 percent*

*This total is higher than the +0.2 percent adjustment that was included in the proposed rule because CMS did not finalize its proposal to make a prospective documentation and coding adjustment to account for estimated overpayments in FY 2010.

Other Changes in the IPPS/LTCH PPS Final Rule:

New Technology Add-On Payments For FY2013: To remove barriers to access for costly new technologies that are not yet fully reflected in the current MS-DRG payment rates, the Medicare law provides for temporary add-on payments for inpatient stays that involve the use of certain approved new technologies. CMS is approving new technology add-on payments for three applications, glucarpidase (Voraxaze®), fidaxomicin (DIFICID™), and the Zenith® Fenestrated Abdominal Aortic Aneurysm (AAA) Endovascular Graft.

Voraxaze® can be used to rapidly reduce toxic concentrations of methotrexate, a chemotherapy drug that can cause renal impairment in patients being treated for cancer. DIFICID™ is an oral medication used to treat *Clostridium difficile*-associated diarrhea (CDAD), a common hospital acquired illness that can result from treatment with antibiotics. The Zenith® Fenestrated AAA Endovascular Graft is an implantable device designed to treat patients who have an abdominal aortic aneurysm and but are not candidates for treatment with open surgery or other grafts on the market

because they have unique anatomical issues. Additionally, CMS is extending through FY 2013, the new technology add-on payment for the AutoLITT™, an MRI guided treatment for the removal of brain tumors.

Inclusion of Labor and Delivery Beds in the Available Bed Count for the Disproportionate Share Hospital (DSH) Adjustment and Indirect Medical Education (IME) Adjustment: CMS is finalizing inclusion of labor and delivery days in the count of available beds for purposes of both the Medicare DSH and IME adjustments. This change will align with the CMS policy, adopted in FY 2010, to include labor and delivery days in the patient day count for the Medicare DSH adjustment. CMS is also applying the timely filing requirements to the submission of no pay bills for purposes of calculating the DSH adjustment.

Postponement of "Services Under Arrangement" Requirements: In the FY 2012 IPPS/LTCH PPS final rule CMS finalized the policy that therapeutic and diagnostic services are the only services that may be furnished under arrangement outside of the hospital to Medicare beneficiaries. Routine services (that is, bed, board, and nursing and other related services) must be furnished by the hospital. Some hospitals have stated they need additional time to restructure existing arrangements and establish necessary operational protocols to comply with the policy. Therefore, CMS is postponing the effective date of the policy that limits "services under arrangement" to diagnostic and therapeutic services. This policy will now be effective for hospital cost reporting periods beginning on or after October 1, 2013.

Graduate Medical Education (GME): CMS is including several changes and clarifications of existing policy regarding GME in this rule. CMS is extending the timeframe for teaching hospitals that qualify to establish their caps for new programs from three years to five years. CMS is also making changes regarding the five-year period following the implementation of increases to hospitals' full-time equivalent (FTE) resident caps under section 5503 of the Affordable Care Act. CMS is changing and clarifying existing policy related to the application of section 5506 of the Affordable Care Act, which preserves resident cap positions from closed hospitals. In addition, CMS is clarifying that timely filing rules for claims submission apply to no-pay claims submitted by hospitals to receive indirect medical education, direct medical education and nursing and allied health education payments for Medicare Advantage beneficiaries.

Additions to the list of Hospital Acquired Conditions (HACs): CMS is adding two categories of conditions to the list of HACs in FY 2013, Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization.

For more information on quality-related provisions in this rule, please see www.cms.gov/apps/media/fact_sheets.asp.

Expiring Provisions:

Medicare-Dependent Hospital (MDH) Program: Under current law, the MDH program will expire at the end of FY 2012, that is, for discharges occurring after September 30, 2012. Accordingly, beginning in FY 2013, hospitals that are currently paid under the MDH program will instead be paid based on the Federal rate as are other IPPS hospitals (unless they can also qualify as sole community hospital) .

Low-Volume Hospital Payment Adjustment: Prior to 2011, a low- volume hospital had to be at least 25 miles from the nearest hospital and have less than 800 total discharges. For FY 2011 and FY 2012, sections 3125 and 10314 of the Affordable Care Act defined a low-volume hospital as being more than 15 road miles from other IPPS hospitals and having fewer than 1,600 Medicare discharges. Payment adjustments were made on a sliding scale with a higher adjustment for hospitals with fewer discharges and a lower adjustment for hospitals with higher discharges.

Effective for FY 2013 and forward, the low-volume hospital definition and payment adjustment methodology will return to the pre-2011 definition and payment adjustment methodology. Hospitals that qualify for the low-volume hospital adjustment will receive a 25 percent adjustment rather than an adjustment based on a sliding scale.

POLICIES AFFECTING LONG-TERM CARE HOSPITALS

Changes to Payment Rates under the LTCH PPS: CMS projects that LTCH PPS payments will increase by 1.7 percent, or approximately $92 million, in FY 2013. This estimated increase is attributable to several factors, including the update of 1.8 percent (based on a market basket update of 2.6 percent reduced by a multi-factor productivity adjustment of 0.7 percentage point and an additional 0.1 percentage point reduction in accordance with the Affordable Care Act); the "one-time" budget neutrality adjustment of approximately -1.3 percent (the first year of a 3 year phased-in adjustment) to the FY 2013 standard Federal rate (which is not applicable to payments for discharges occurring on or before December 28, 2012); and, projected increases in estimated high cost outliers and decreases in short-stay outlier (SSO) payments due to a change in the SSO payment methodology effective for discharges occurring on or after December 29, 2012.

Expiration of Moratoria Established Under the Medicare Statute: In the Medicare, Medicaid and SCHIP Extension Act of 2007, Congress imposed a three-year moratorium on the effective date of certain LTCH PPS payment policies. At the same time, Congress imposed a three-year moratorium on the development of new LTCHs and LTCH satellites and on increases in the number of LTCH beds in existing LTCHs and LTCH satellite facilities, unless an exception applied. The payment policies subject to the moratorium included:

- Inclusion of the "IPPS comparable per diem amount" option for very short stay cases in the short-stay outlier (SSO) payment formula;
- Implementation of the "25 percent threshold" payment adjustment; and
- Application of a one-time prospective budget neutrality adjustment to the standard Federal rate.

The Affordable Care Act extended the moratoria for two more years, with the moratoria expiring at various times during CY 2012.

With the expiration of the moratoria, CMS will apply the "IPPS-comparable per diem amount" option to payment determinations made under the SSO policy for discharges with a certain length of stay beginning on and after December 29, 2012.

However, the rule includes an extension of the moratorium on the implementation of the "25 percent threshold" payment policy that is generally effective for cost reporting periods beginning on or after October 1, 2012 and before October 1, 2013. For certain LTCHs and LTCH satellites with cost-reporting periods beginning on or after July 1, 2012 and before October 1, 2012, we are also providing a supplemental moratorium effective for discharges occurring on or after October 1, 2012 and through the end of the cost reporting period. This extension is being finalized as proposed in light of CMS's ongoing research which may result in LTCH payment policies that could eliminate the need for the 25 percent rule.

CMS is also applying a one-time prospective adjustment to the standard Federal rate so any significant difference between the data used in the original computations for budget neutrality for FY 2003 and more recent data is not perpetuated in the Prospective Payment System in future years. The rule establishes a permanent 3.75 percent payment reduction to the standard Federal rate to be phased in over three years. The adjustment for FY 2013 is approximately -1.3 percent. The adjustment will not apply to payments for discharges occurring on or before December 28, 2012, consistent with the statute.

Development of the Long-Term Care Hospital-Specific Market Basket: CMS is adopting a stand-alone LTCH-specific market basket based solely on LTCHs' Medicare cost report data that specifically reflect the cost structures of LTCHs. This market basket will replace the Rehabilitation, Psychiatric, and Long-Term Care Hospital (RPL) market basket used under the LTCH PPS prior to FY 2013.

The final IPPS/LTCH PPS rule can be downloaded from the *Federal Register* at:

http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

It will appear in the August 31, 2012 *Federal Register*.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 03 - VALLEY HOSPITAL B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Statute is not met as evidenced by: Based on observation, the facility failed to ensure the sprinkler system was maintained and sprinkler piping or hangers were not used to support non-system components (NFPA 13, 9-1.1.7). The findings include: Observation on May 22, 2006, between 10:00 a.m. and 12:30 p.m., revealed the mechanical room in the RTC area and the electrical/riser room near the New Reflections area had wiring and conduit supported by and tie wrapped to sprinkler piping.	H 871		

Parkridge Medical Center
Parkridge East Hospital* Parkridge Valley**

*A Facility of Parkridge Medical Center
**A Behavioral Health Facility of Parkridge Medical Center

TRISTAR HEALTH SYSTEM.

June 14, 2006

Ms. Faye Vance
Bureau of Health Licensure and Regulation
Lakeshore Park, Building 1
5904 Lyons View Pike
Knoxville, TN 37919

Dear Faye,

Thank you for facilitating our understanding last week of the official state report in response to the Licensure Survey that occurred May 22, 2006 through May 24, 2006. We have already completed several corrections as indicated in the body of the Plan of Correction.

As we discussed by phone, our team found the report(s) difficult to interpret due to the following items:

1. The theme of "Facility A, B, C" did not consistently identify the deficiencies. We were able to identify the designated hospital by interviewing our personnel here.
2. We were unaware of the extent of the Fire Marshal's report since we were not provided a summary at the time of survey.
3. The Fire Marshal identified one utility room "on the 5th floor" but it was not clear which one as we have more than one.
4. One report went to Parkridge East, and the others came to Parkridge Medical Center (PMC). We are accustomed to receiving a complete report at PMC, the main campus to encompass the whole organization. All three hospitals are under one licensure.
5. The reports related to the pediatric trauma designation survey were separate for Parkridge East, but for PMC, the report was embedded in other deficiencies such as adult patient care and hazardous waste.

Due to the reasons cited above, I had asked for an extension to June 19, 2006 as a due date for our plan (due 10 days after receiving the report).

If you have any questions about our response, please direct those to me at 423-493-1379. You may also email me at judi.ketchersid@hcahealthcare.com.

I think you corrected your information when we talked by phone, but just to be sure:

* "Hospital B" is now named Parkridge East Hospital (not East Ridge Hospital)
* The CEO at Parkridge East is Mark Sims, not Jerri Underwood.

Thank you again for your assistance in improving our understanding of these reports.

Judi Ketchersid
Regulatory Standards Director
Parkridge Medical Center, Inc.
Chattanooga, TN

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-1 Initial This Statute is not met as evidenced by: An onsite licensure survey was conducted from May 22, 2006 through May 24, 2006, at the three facilities included within the Parkridge Medical Center, Inc. From purposes of clarification, in this Statement of Deficiency, Parkridge Medical Center on McCallie Avenue will be referred to as Hospital A. Parkridge East Hospital will be referred to as Hospital B and Parkridge Valley Hospital will be referred to as Hospital C. An entrance conference was conducted at Hospital A at 10:00 a.m., on May 22, 2006, with the Chief Nursing Executive, the Associate Nursing Officer, the Vice President of Quality, and the Vice President of Education. An entrance conference was conducted at Hospital B at 10:00 a.m., May 22, 2006, with the Chief Executive Officer and the Chief Nursing Officer. An entrance conference was conducted at Hospital C at 8:00 a.m., on May 23, 2006, with the Chief Nursing Executive, Director of Adult Services, Director of Child and Adolescent Services, and Director of Quality and Risk Management. An exit conference pertaining to all 3 facilities surveyed was provided at Hospital A on May 24, 2006, at 1:45 p.m., with the Chief Nursing Executive and several additional administrative staff members in attendance. Survey findings were shared and questions were answered.	H 001	Corrections begin Page 2.	

Division of Health Care Facilities

Judith C. Ledbetter

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Regulatory Standards Director (X6) DATE 6/1/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

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H 681	Continued From page 1	H 681		
H 681	1200-8-1-.06 (4)(j) Basic Hospital Functions (4) Nursing Services. (j) All drugs, devices and related materials must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures This Statute is not met as evidenced by: Facility B Based on observation, medical record review, and interview, the facility failed to assure a physician's order was carried out for one (#7) of ten residents sampled. The findings included: Medical record review revealed the patient was admitted on May 22, 2006, with diagnosis including Urinary Tract Infection. Medical record review revealed a Physician's Order dated May 22, 2006, at 9:48 a.m., "...D/C (discontinue) (named) catheter (system to drain urine)..." Observation of the patient on May 23, 2006, at 2:00 p.m., revealed the patient lying in bed with a catheter in place. Interview with the Manager of the Medical Surgical Unit on May 23, 2006, at 2:00 p.m., confirmed the order to discontinue the catheter had not been carried out. Based on observation and interview, the facility failed to ensure medications had not expired for the emergency department's pediatric crash cart.	H 681	Corrective action regarding the patient affected by the deficient practice: the physician was contacted immediately regarding the Foley and an order was received to discontinue the previous order to D/C the Foley. An order was also received to consult physical therapy to evaluate functional status of the patient with a goal of removing the Foley. After this evaluation, the Foley was discontinued when the patient's functionality was able to support bathroom privileges as ordered. Corrective action to identify other patients at risk: Counseling was immediately provided to those nurses who had not responded to the physician order. This should prevent the same practice from recurring. Systemic changes: A formal educational program to all staff nurses will occur at the next staff meeting. Monitoring: The unit director will monitor implementation of all physician orders during her routine chart reviews.	Complete Complete Complete 7/9/06 Continuous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN053166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

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H 681	Continued From page 2 The findings included: Observation of the pediatric crash cart in the emergency room on May 23, 2006, at 10:30 a.m., revealed the following drugs had expired: 1. 2 vials of Aminophylline expired 4-1-06 2. 2 vials of Calcium Gluconate expired 2-06 3. 2 Dextrose pediatric syringes expired 4-1-04 4. 6 Sodium Bicarbonate pediatric syringes expired 5-1-06 5. 2 vials of Adenocard expired 3-06. Interview with the Director of the Emergency Department at the time of discovery confirmed the facility failed to ensure medications for the pediatric crash cart had not expired.	H 681	Facility A Corrective action regarding the patient affected by the deficient practice: No specific patient was affected. Corrections to prevent recurrence: 1. The pharmacy inspection checklist will highlight the location of pediatric crash carts. 2. The procedure for floor inspections and the checklist will be reviewed by entire pharmacy technician staff. 3. The pharmacy director will validate pharmacy staff knowledge by performing walk-throughs with each assigned pharmacy technician in their area. 4. A pharmacy technician will be assigned to monitor compliance with monthly inspections. 5. A signature log will be kept and sent to QM by June 30 to ensure each technician has been educated on the crash cart inspection process.	6/30/06
H1031	1200-8-1-.10 (11) Infectious Waste and Hazardous Waste (11)All garbage, trash and other non-infectious waste shall be stored, transported, and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, constructed of easily-cleanable material and shall be kept on elevated platforms. Authority: T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209 and 68-11-216. This Statute is not met as evidenced by: Facility B Based on observation and interview, the facility failed store garbage in a manner to prevent transmission of disease and prohibit a breeding place for insects and rodents for one of one trash compactor.	H1031	Corrective action to identify other patients at risk: Counseling was immediately provided to pharmacy staff and nurses at the point of care who were involved in checking for expiration dates. This should prevent the same practice from recurring. Systemic changes: A formal educational program to all ED staff nurses will occur by June 14, 2006. Monitoring: The ED director will perform spot checks of the pediatric code cart to assure the tag does not indicate out of date medications.	Complete Complete Continuous

Roberts C. Catchings
Regulatory Standards Director
6/17/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1031	Continued From page 3 The findings included: Observation and interview with the Supervisor of the Dietary Department on May 22, 2006, at 1:00 p.m., revealed the open area of the trash compactor for depositing trash to be compacted contained numerous large garbage bags filled with trash. Several of the bags had a white liquid on the outside of the bags. Two of the bags were punctured. The supervisor confirmed the trash had not been compacted and the trash was not to be left exposed.	H1031	Corrective actions: No specific patient was affected by this deficiency. Corrective Action to prevent recurrence of trash being left at the compactor: the specific employee involved was counseled to assure all trash is compacted before leaving the dock area. This employee was counseled to always carry the compactor key on pick up rounds. Each employee in the Environmental department services was educated regarding compacting the trash when it is first carried out. System Changes: An immediate assessment was made of all personnel who had been issued keys to the compactor to assure employees did have the ability to compact the trash when carried out and before leaving the compactor dock. Monitoring: The engineering director will monitor the compacting dock on regular safety rounds.	Complet Complet Comple Contin

Regulatory Standards Director 6/12/0

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNSAT004	A. BUILDING _____ B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE EAST HOSPITAL	941 SPRING CREEK ROAD CHATTANOOGA, TN 37412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 314	1200-8-30-.03 (1)(j)3 Administration (1) The hospital administration shall provide the following: (j) Incorporation into the hospital existing quality assessment and improvement program, a review of the following pediatric issues and indicators: 3. child abuse cases; This Statute is not met as evidenced by: Surveyor: 21160 Based on observation and interview, the facility failed to maintain information to track issues and indicators of suspected child abuse cases. The findings included: Observation and interview with the Director of the ED (Emergency Department) on May 23, 2006, at 9:20 a.m., revealed the Pediatric Facility Notebook did not contain a listing of cases of suspected child abuse for reference in the event the child was seen again in the ED at a later date. The ED Director confirmed the only information available was in the closed record and if the physician or staff did not request the closed record, the physician or staff would have no way of knowing the child had a prior report to the proper authorities of suspected child abuse.	P 314	Corrective Actions regarding specific patient: No known specific patient was affected by this deficiency. Plan immediately past survey: Implemented a tool to include listing of all suspected child abuse cases to be maintained as a reference for pediatric admissions RT fractures, burns, failure to thrive or other S/S that would indicate possible abuse. Staff was educated regarding the use of this log. Corrective Action to provide reference information on previously admitted pediatric patients who may have experienced child abuse: The department director instituted a log of pediatric ED admissions that may have been suspected for child abuse issues. This log has been placed in a strategic place at the nursing station so staff will have easy reference for subsequent admissions. Systemic Changes: A formal education has occurred using individual counseling and email to instruct ED staff how to utilize the log. The objective of the education is to inform staff in the use of the log to recognize a repeated pediatric admission who may be at risk. Monitoring: The department director will monitor this log regularly as part of the department level quality activities. Any issues found when the logs are analyzed will be addressed at the unit level and reported to the Quality Council if applicable to the facility.	Complete Complete Complete Continuous

Judith C. Fetchersid — Regulatory Standards Director — 6/12/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET: DATE
P 314	1200-8-30-.03 (1)(j)3 Administration (1) The hospital administration shall provide the following: (j) Incorporation into the hospital existing quality assessment and improvement program, a review of the following pediatric issues and indicators: 3. child abuse cases; This Statute is not met as evidenced by: Based on observation and interview, the facility failed to monitor for required pediatric issues and indicators of child abuse cases. The findings included: Observation of the Emergency Department (ED) on May 23, 2006, at 9:00 a.m., and review of the Pediatric Facility Notebook (PFN) revealed no documentation or monitoring of pediatric visits. Review of the PFN revealed no documentation or monitoring of pediatric care to include age, admissions, diagnosis, length of stay, transfers, or outcomes. Interview with the Director of the ED on May 23, 2006, at 10:00 a.m., confirmed child abuse cases are not incorporated into the hospital quality assessment or quality improvement programs and the facility has no collaboration with the Comprehensive Regional Pediatric Center (CRPC) regarding the assessment and improvement programs.	P 314	Facility "A" Corrective Actions regarding specific patient: No known specific patient was affected by this deficiency. Immediate corrective action during the survey: the PMC Emergency Department Director was added to the Comprehensive Regional Pediatric Center meeting attendees so that regular attendance/participation will be a part of his activities. Plan immediately past survey: Implemented a tool to include listing of all pediatric cases including columns on age, admissions, diagnosis, length of stay, transfers , or outcomes and previously suspected/reported child abuse cases such as RT fractures, burns, failure to thrive or other S/S that would indicate possible abuse. Staff will be educated regarding the use of this notebook. A report listing of pediatric transfers will be presented to the department director by information services on a quarterly basis so that these cases may be analyzed for quality improvement.	Complete Complete Complete
P 319	1200-8-30-.03 (1)(j)8 Administration (1) The hospital administration shall provide the following: (j) Incorporation into the hospital existing quality assessment and improvement program, a review of the following pediatric issues and indicators:	P 319		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Judith C. Ketchersid Regulatory Standards Director 6/12/06

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 319	Continued From page 1 6. pediatric transfers; and This Statute is not met as evidenced by: Based on observation and interview, the facility failed to monitor for required pediatric issues and indicators of pediatric transfers. The findings included: Observation of the Emergency Department (ED) on May 23, 2006, at 9:00 a.m., and review of the Pediatric Facility Notebook (PFN) revealed no documentation or monitoring of the pediatric visits. Interview with the Director of the ED on May 23, 2006, at 10:00 a.m., confirmed the issue of pediatric transfers is not incorporated into the hospital quality assessment or quality improvement programs and the facility has no collaboration with the Comprehensive Regional Pediatric Center (CRPC) regarding the assessment and improvement programs.	P 319	Corrective Action to provide reference information on previously admitted pediatric patients who may have experienced child abuse: The department director instituted a notebook/log of pediatric ED admissions that may have been suspected for child abuse issues. This log has been placed in a strategic place at the nursing station so staff will have easy reference for subsequent admissions. The IS department has been notified to provide regular pediatric transfer reports for analysis. Systemic Changes: Formal education has occurred using individual counseling and email to instruct ED staff how to utilize the notebook/log. The objective of the education is to inform staff in the use of the documents to recognize a repeated pediatric admission who may be at risk. Monitoring: The ED department director will monitor this notebook, the log, and the transfer list regularly as part of the department level quality activities. Any issues found when the documents/reports are analyzed will be addressed at the unit level and reported to the Quality Council if applicable to the facility.	Complete Complete Complete
P 501	1200-8-30-.05 (1)(a) Basic Functions (1) Medical Seivices. (a) In a Basic Pediatric Emergency Facility an on-call physician shall be promptly available and provide direction for the in-house nursing staff. The physician shall be competent in the care of pediatric emergencies including the recognition and management of shock and respiratory failure, the stabilization of pediatric trauma patients, advanced airway skills (intubation, needle thoracostomy), vascular access skills (including intraosseous needle insertion), and be able to perform a thorough screening neurologic assessment and to interpret physical signs and laboratory values in an age-appropriate manner. For physicians not board-certified/prepared by the	P 501	Facility "B" – Medical Servicao – page 3	

Judith Ketchersid Regulatory Standards Director 6/15/0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
P 501	Continued From page 2 American Board of Emergency Medicine, ... and successful completion of courses such as Pediatric Advanced Life Support (PALS) or the American Academy of Pediatrics and American College of Emergency Physician's Advanced Pediatric Life Support (APLS) can be utilized to demonstrate this clinical capability. An on-call system shall be developed for access to physicians who have advanced airway and vascular access skills as well as for general surgery and pediatric specialty consultation. A back-up system must be in place for additional registered nurse staffing for emergencies. This Statute is not met as evidenced by: Facility B Based on review of Credentialing Files, the facility's Medical Staff Rules and Regulations, the Emergency Department's Physicians Schedule and interview, the facility failed to ensure that one of two Emergency Physicians had documented competencies for the care of pediatric emergencies for the Basic Designation in the Pediatric Emergency Care Facility. The findings included: Review of Credentialing File #1, an emergency department physician, revealed the physician was not board certified in Emergency Medicine and the Credentialing File had no documented competencies for the care of pediatric emergencies. Review of the Emergency Department's Physicians Schedule for the week of May 14-20, 2006, revealed the physician worked on May 20, 2006, between 2:00 a.m., and 7:00 a.m., as the only Emergency Department Physician. Review of the facility's Medical Staff Rules and Regulations revealed, " ...All Emergency Department Physicians are required	P 501	These Corrections were made immediately. Corrective Actions regarding specific patient: No known specific patient was affected by this deficiency. Immediate corrective action during the survey: The physician whose credentialing document was deficient for required certifications was immediately removed from the emergency room schedule at Facility B. The same physician had applied to Facility A and immediately scheduled required certifications so that he may be credentialed to begin work at Facility A when other appointment documentation was complete.	Complete
			Corrective Action to prevent other physicians from working if certifications are not up to date: The Medical Staff Supervisor will regularly monitor the credentialing files of all emergency room physicians to assure certifications for ACLS, PALS, and ATLS are in place as required.	Complete
			Systemic Changes: ACLS, PALS, and ATLS certification status was previously monitored at initial appointments, elevations, and reappointments. Now they will be monitored with a monthly query to pull non-compliant physicians.	Complete
			If any certifications are close to renewal time, the coordinator will remind the physician to schedule needed classes.	Complete
			Monitoring: This will be reported to credentials committee for oversight and appropriate action.	Complete

Judith C. Lekbrip
Regulatory Standards Director
6/12/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING _____ B. WING _____	05/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 501	Continued From page 3 to maintain certification in ACLS, ATLS, and PALS. Interview with the Administrative Nurse confirmed the Credentialing File had no documented competencies for the care of pediatric emergencies.	P 501		

Robert Ledbetter
Regulatory Standards Director
6/12/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 02 - EASTRIDGE B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Statute is not met as evidenced by: Based on observation, the facility failed to assure smoke detectors were located at least 3 feet from an air supply (NFPA 72, 2-3.5.1). The findings include: Observation on May 22, 2006 at 10:15 a.m. revealed the smoke detectors at the 2W nurses station, 1st floor L&D clean linen room, and day surgery were located (1) foot from an air supply. Based on observation, the facility failed to assure the sprinkler system was maintained and sprinkler piping was not used to support non-system components. (NFPA 13, 9-1.1.7) The findings include: Observation on May 22, 2006 at 1:30 p.m. revealed the 1st floor mechanical room had low voltage wiring supported by and tie wrapped to sprinkler piping.	H 871	Smoke detectors that required correction on 2 West nurses station, 1st floor linen room, and day surgery have been moved at least 3 feet from the air supply. The low voltage wiring attached to the sprinkler piping has been removed. System change: Tie wrapping to sprinkler piping will be prevented in the future through regular inspections past contractor work in areas that may be at risk.	6/8/06 6/8/06 Continuou per occurrence

Patricia Latchessed Regulatory Standards Director — TITLE — 6/12/06 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 03 - VALLEY HOSPITAL B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Statute is not met as evidenced by: Based on observation, the facility failed to ensure the sprinkler system was maintained and sprinkler piping or hangers were not used to support non-system components (NFPA 13, 9-1.1.7). The findings include: Observation on May 22, 2006, between 10:00 a.m. and 12:30 p.m., revealed the mechanical room in the RTC area and the electrical/riser room near the New Reflections area had wiring and conduit supported by and tie wrapped to sprinkler piping.	H 871	This condition has been corrected. Sprinkler piping is free from attachments. Systemic Change: Tie wrapping to sprinkler piping will be prevented in the future through regular inspections past contractor work in areas that may be at risk.	Complete. Continuou per occurrence

Edith Latchem Regulatory Standards Director — TITLE — 6/12/06 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 01 - PARKRIDGE MEDICAL CE B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Statute is not met as evidenced by: Based on observation, the facility failed to assure the corridors in the means of egress were maintained clear of all obstructions (NFPA 101-7.1.10.2.1.) The findings include: Observation on May 22 and 23, 2006 between 8:00 a.m. and 5:00 p.m. revealed the 1st floor rear corridor had three (3) beds and eight (8) clean linen bins along the entire length of the corridor. Observation on May 22, 2006 at 4:30 p.m. and May 23, 2006 between 8:00 a.m. and 9:30 a.m. revealed the rear fire exit by the outdoor Oxygen storage area was blocked by carts. Observation on May 22, 2006 at 10:30 a.m. revealed the main 2nd floor rear corridor had two (2) beds, two (2) MRI dollies, and two (2) portable X-ray machines in the corridor. Observation on May 22, 2006 at 11:30 a.m. revealed the radiology corridor had six (6) chairs in the corridor, seven (7) empty portable oxygen carriers, an IV pole, and a 2-drawer cabinet. Based on observation, the facility failed to assure smoke detectors were located at least 3 feet from	H 871	Beds and other items have been removed from the corridor. Signage has been ordered, the expected delivery date is 6/23/06. Daily monitoring for clearance shall be performed by the Engineering Department and the Director of Engineering. Items have been removed from the Fire Exit. Signage has been ordered, the expected delivery date is 6/23/06. Daily monitoring for clearance shall be performed by the Engineering Department and the Director of Engineering. Items have been removed from the corridor. Signage has been ordered, the expected delivery date is 6/23/06. Daily monitoring for clearance shall be performed by the Engineering Department and the Director of Engineering for compliance. Chairs and other items have been removed from the corridor. Signage has been ordered, the expected delivery date is 6/23/06. Daily monitoring for clearance shall be performed by the Engineering Department and the Director of Engineering.	6/30 6/30 6/30 6/30

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATE FORM 6899 VFPX21 If continuation sheet 1 of 4

Judith C. Ketchersid — Regulatory Standards Director — 6/12/06

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 01 - PARKRIDGE MEDICAL CE B. WING _____	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	Continued From page 1 an air supply (NFPA 72, 2-3.5.1). The findings include: Observation on May 22, 2006 at 2:35 p.m. revealed the smoke detectors on the 1st floor corridor outside the Materials Management rear entrance was one (1) foot from an air supply. Observation on May 22, 2006 at 2:50 p.m. revealed the smoke detectors on the 2nd floor corridor at the elevator lobby was one (1) foot from an air supply. Observation on May 22, 2006 at 4:50 p.m. revealed the A and D first floor elevators were not provided with smoke detectors at their rear lobby area. Based on observation, the facility failed to assure hazardous area one (2) hour fire rated construction is maintained. The findings include: Observation on May 23, 2006 at 2:00 p.m. revealed the 1st floor mechanical room (old generator room) had a 2-hour rated wall with an unsealed chiller box in the corridor wall. Maintenance personnel indicated this is no longer being used.	H 871	Smoke detector has been moved at least 3' from the air supply diffuser. Smoke detector has been moved at least 3' from the air supply diffuser Smoke detectors have been ordered from the appropriate contractor, delivery date was given of 6/23/06. Detectors shall be installed upon receipt and proper operation verified by the Director of Engineering. Unit as been sealed with the appropriate rated Fire Caulking. The operational status of the unit is being evaluated by the Engineering Department.	Complete Complete 7/7/06 Complete
H 872	1200-8-1-.08 (2) Building Standards (2) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.	H 872		

Judith C. Lackey
Regulatory Standards Director
6/12/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 01 - PARKRIDGE MEDICAL CE B. WING	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID. PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 872	Continued From page 2 This Statute is not met as evidenced by: Based on observation, the facility failed to assure oxygen bottles are secured and No Smoking signs were provided in areas where oxygen is used or stored (NFPA 99, 8.6.4.2). The findings include: Observation on May 22, 2006 between 8:00 a.m. and 4:30 p.m. revealed the following areas have unsecured oxygen bottles, and no signs in place stating "No Smoking oxygen in use" where oxygen is stored or in use: 1. Fifth floor soiled utility. 2. Fifth floor respiratory therapy room. 3. Loading dock oxygen storage area. 4. Four west oxygen storage room. 5. Cardiac recovery unit. 6. MICU storage room.	H 872	Signage installed and will be monitored by Zone Mechanics on daily rounds.	Complete
H 893	1200-8-1-.08 (23) Building Standards. (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Statute is not met as evidenced by: Based on observation, the facility failed to assure soiled linen storage areas were well ventilated and maintained under a relative negative air pressure. The findings include:	H 893		

Regulatory Standards Director 6/12/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53166	A. BUILDING 01 - PARKRIDGE MEDICAL CE B. WING	05/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE MEDICAL CENTER	2333 MCCALLIE AVE CHATTANOOGA, TN 37404

(X4) ID-PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 893	Continued From page 3 Observation on May 23, 2006 at 10:30 a.m. revealed the surgery soiled utility room has no negative air pressure.	H 893	**Initial investigation of this issue revealed that at sometime in past renovations the exhaust air duct was terminated to the exhaust fan. At this time the Director of Engineering and the appropriate contractors are reviewing the options of reconnecting the duct work to the exhaust fan. Negative pressure shall be verified by an independent/licensed Air Balance Contractor. Once project is complete the Director of Engineering will forward a letter of completion to the State Fire Marshal's office.**	**The Director of Engineering will provide in writing when the project is complete** Target Date: July 9 2006

Judith C. Tetchenip
Regulatory Standards Director
6/12/06

The Joint Commission

Parkridge Medical Center, Inc.
2333 McCallie Avenue
Chattanooga, TN 37404

Organization Identification Number: 7815

Program(s)	**Survey Date(s)**
Hospital Accreditation	06/13/2011-06/16/2011
Behavioral Health Care Accreditation	

Executive Summary

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Rundate: 12/13/2012 10:40:19 AM ELARPT

Hospital: Memphis Facility #: 422

Expanded Labor Analysis Monthly Report - Therapy

Calendar Year: 2011

PPD Breakdown	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
Patients Days	1,161.00	1,079.00	1,165.00	1,128.00	1,182.00	1,099.00	1,051.00	1,078.00	1,046.00	1,012.00	1,055.00	1,141.00	13,197.00
Total PT Hours PPD (2)	.27	.29	.44	.43	.39	.46	.41	.47	.38	.47	.47	.41	.41
Total OT Hours PPD (2)	.29	.19	.01										.04
Total ST Hours PPD (2)	.13	.13	.12	.13	.13	.15	.13	.14	.13	.13	.14	.11	.13
Total RT Hours PPD (2)	1.96	2.09	2.40	2.55	2.64	2.70	2.73	2.75	2.69	2.89	2.93	2.76	2.58
Total Agency Hours PPD (3)			.03	.03	.03	.06	.04	.04	.02	.20	.09	.25	.07
Total Therapy Hours PPD (1)	2.65	2.71	3.00	3.13	3.19	3.37	3.32	3.39	3.22	3.68	3.64	3.52	3.23

Rundate: 12/13/2012 12:55:14 PM

ELARPT

Hospital: Memphis Facility #: 422

Expanded Labor Analysis Monthly Report - Therapy

Calendar Year: 2012

PPD Breakdown	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
Patients Days	1,188.00	1,114.00	1,173.00	1,070.00	1,151.00	1,138.00	1,145.00	1,062.00	1,018.00	1,118.00	1,066.00	403.00	12,646.00
Total PT Hours PPD (2)	.42	.43	.41	.42	.42	.38	.41	.34	.28	.36	.40	.41	.39
Total OT Hours PPD (2)							.04	.22	.26	.15	.09	.10	.07
Total ST Hours PPD (2)	.13	.12	.08	.13	.12	.10	.13	.14	.13	.16	.06	.04	.11
Total RT Hours PPD (2)	2.63	2.31	2.50	2.74	2.51	2.49	2.32	2.34	2.50	2.15	2.09	2.22	2.41
Total Agency Hours PPD (3)	.24	.18	.12										.05
Total Therapy Hours PPD (1)	3.42	3.05	3.11	3.30	3.05	2.97	2.89	3.05	3.17	2.82	2.63	2.76	3.03

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Hospital: Memphis Facility #: 422
Expanded Labor Analysis Monthly Report - Nursing
Calendar Year: 2011

PPD Breakdown	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
Patients Days	1,161.00	1,079.00	1,165.00	1,128.00	1,182.00	1,099.00	1,051.00	1,078.00	1,046.00	1,012.00	1,055.00	1,141.00	13,197.00
Total RN Hours PPD (2)	4.97	4.53	4.81	5.14	4.69	4.65	4.75	4.44	4.45	4.08	4.53	4.00	4.59
Total LPN Hours PPD (2)	.53	.55	.68	.66	.53	.52	.65	.58	.53	.47	.51	.38	.55
Total CNA Hours PPD (2)	3.13	2.83	2.96	2.74	2.70	2.86	2.89	3.48	3.84	4.35	4.15	4.17	3.33
Total Agency Hours PPD (3)	.68	.67	.78	1.31	1.57	1.82	1.52	1.64	1.68	.96	.92	.57	1.17
Total Nursing Hours PPD (1)	9.30	8.57	9.24	9.85	9.49	9.85	9.81	10.14	10.50	9.86	10.11	9.13	9.64

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Hospital: Memphis Facility #: 422

Expanded Labor Analysis Monthly Report - Nursing

Calendar Year: 2012

PPD Breakdown	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
Patients Days	1,188.00	1,114.00	1,173.00	1,070.00	1,151.00	1,138.00	1,145.00	1,062.00	1,018.00	1,118.00	1,066.00	403.00	12,646.00
Total RN Hours PPD (2)	4.42	4.57	4.65	4.92	4.99	4.74	4.52	4.85	4.91	4.69	5.39	6.09	4.82
Total LPN Hours PPD (2)	.49	.40	.43	.51	.50	.45	.39	.45	.54	.58	.54	.51	.48
Total CNA Hours PPD (2)	4.11	3.36	3.97	4.40	3.99	3.96	3.61	3.88	3.96	3.89	3.86	3.91	3.91
Total Agency Hours PPD (3)	.59	1.22	1.06	.98	1.04	.81	.76	.60	.30	.08			.66
Total Nursing Hours PPD (1)	9.60	9.56	10.12	10.81	10.52	9.98	9.30	9.78	9.71	9.24	9.79	10.51	9.87

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Filter By Alabama Provider Type

Alabama Adult Day Care Center
Alabama Alzheimers Center
Alabama Assisted Living
Alabama Behavioral Health Center
Alabama Dialysis Center
Alabama Home Dialysis
Alabama DME Dialysis
Alabama Durable Medical Equipment General
Alabama Durable Medical Equipment Nutrition
Alabama DME Oxygen
Alabama Home Health Care
Alabama Hospice Care Center
Alabama Hospice Service
Alabama Acute Care Hospital
Alabama Long Term Acute Care Hospital
Alabama Intermediate Care Facility
Alabama IV Infusion
Alabama Long Term Respiratory Care
Alabama Neurology Clinic
Alabama Nursing Home
Alabama Personal Care Home
Alabama Outpatient Rehab
Alabama Inpatient Rehabilitation Facility
Alabama Nursing Home Rehabilitation
Alabama Respiratory Therapy Agency
Alabama Sleep Disorder Clinic
Alabama Medical Transport Service

Alabama Long Term Acute Care Hospital Directory

Infirmary LTAC Hospital
Long Term Acute Care Hospital
5644 Girby Road Box 9753
Mobile, Alabama 36693
(more details on this long term acute care hospital)

Noland Hospital Anniston
Long Term Acute Care Hospital
400 East Tenth Street, 4th Floor
Anniston, Alabama 36202
(more details on this long term acute care hospital)

Noland Hospital Birmingham
Long Term Acute Care Hospital
50 Medical Park Dr. East, 8th Floor
Birmingham, Alabama 35261
The Long Term Hospital of Birmingham is a 45 bed long term acute care hospital (LTACH) located in th ...
(more details on this long term acute care hospital)

Noland Hospital Dothan
Long Term Acute Care Hospital
1108 Ross Clark Circle, Floor 4
Dothan, Alabama 36301
(more details on this long term acute care hospital)

Noland Hospital Montgomery
Long Term Acute Care Hospital
1725 Pine Street, 5 North
Montgomery, Alabama 36106
(more details on this long term acute care hospital)

Noland Hospital Shelby
Long Term Acute Care Hospital
1000 First St. North, 3rd Floor
Alabaster, Alabama 35007
(more details on this long term acute care hospital)

Noland Hospital Tuscaloosa
Long Term Acute Care Hospital
809 University Boulevard East, 4th Floor
Tuscaloosa, Alabama 35401
(more details on this long term acute care hospital)

Select Specialty Hospital - B'ham
Long Term Acute Care Hospital
800 Montclair Road, 9th Floor
Birmingham, Alabama 35213

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Filter By Arkansas Provider Type

Arkansas Adult Day Care Center
Arkansas Alzheimers Center
Arkansas Assisted Living
Arkansas Behavioral Health Center
Arkansas Dialysis Center
Arkansas Home Dialysis
Arkansas DME Dialysis
Arkansas Durable Medical Equipment General
Arkansas Durable Medical Equipment Nutrition
Arkansas DME Oxygen
Arkansas Home Health Care
Arkansas Hospice Care Center
Arkansas Hospice Service
Arkansas Acute Care Hospital
Arkansas Long Term Acute Care Hospital
Arkansas Intermediate Care Facility
Arkansas IV Infusion
Arkansas Long Term Respiratory Care
Arkansas Neurology Clinic
Arkansas Nursing Home
Arkansas Personal Care Home
Arkansas Outpatient Rehab
Arkansas Inpatient Rehabilitation Facility
Arkansas Nursing Home Rehabilitation
Arkansas Respiratory Therapy Agency
Arkansas Sleep Disorder Clinic
Arkansas Medical Transport Service

Arkansas Long Term Acute Care Hospital Directory

Advance Care Hospital of Fort Smith
Long Term Acute Care Hospital
7301 Rogers Avenue, Floor 4
Fort Smith, Arkansas 72917
(more details on this long term acute care hospital)

Advance Care Hospital of Hot Springs
Long Term Acute Care Hospital
300 Werner Street, Third Floor East
PO Box 29001
Hot Springs, Arkansas 71903
(more details on this long term acute care hospital)

Regency Hospital Of Northwest Arkansas
Long Term Acute Care Hospital
1125 N College Ave
Fayetteville, Arkansas 72703
(more details on this long term acute care hospital)

Regency Hospital of Springdale
Long Term Acute Care Hospital
609 West Maple Avenue, 6th Floor
Springdale, Arkansas 72764
(more details on this long term acute care hospital)

Select Specialty Hospital - Little Rock
Long Term Acute Care Hospital
2 St Vincent Circle, Sixth Floor
Little Rock, Arkansas 72205
(more details on this long term acute care hospital)

SemperCare Hospital - Little Rock
Long Term Acute Care Hospital
9601 Exit Interstate 630 7
Little Rock, Arkansas 72205
(more details on this long term acute care hospital)

Sparks Regional Medical Center
Long Term Acute Care Hospital
PO Box 17006
Fort Smith, Arkansas 72917
(more details on this long term acute care hospital)

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Filter By Mississippi Provider Type

Mississippi Adult Day Care Center
Mississippi Alzheimers Center
Mississippi Assisted Living
Mississippi Behavioral Health Center
Mississippi Dialysis Center
Mississippi Home Dialysis
Mississippi DME Dialysis
Mississippi Durable Medical Equipment General
Mississippi Durable Medical Equipment Nutrition
Mississippi DME Oxygen
Mississippi Home Health Care
Mississippi Hospice Care Center
Mississippi Hospice Service
Mississippi Acute Care Hospital
Mississippi Long Term Acute Care Hospital
Mississippi Intermediate Care Facility
Mississippi IV Infusion
Mississippi Long Term Respiratory Care
Mississippi Neurology Clinic
Mississippi Nursing Home
Mississippi Personal Care Home
Mississippi Outpatient Rehab
Mississippi Inpatient Rehabilitation Facility
Mississippi Nursing Home Rehabilitation
Mississippi Respiratory Therapy Agency
Mississippi Sleep Disorder Clinic
Mississippi Medical Transport Service

Mississippi Long Term Acute Care Hospital Directory

Greenwood Leflore Hospital
Long Term Acute Care Hospital
PO Box 1410
Greenwood, Mississippi 38935
(more details on this long term acute care hospital)

Promise Specialty Hospital Of Vicksburg
Long Term Acute Care Hospital
1111 North Frontage Road 2D Floor
Vicksburg, Mississippi 39180
(more details on this long term acute care hospital)

Regency Hospital Of Hattiesburg
Long Term Acute Care Hospital
6051 Us Highway 49 5th Floor
Hattiesbg, Mississippi 39404
(more details on this long term acute care hospital)

Regency Hospital of Jackson
Long Term Acute Care Hospital
West Tower, Suite 1054
971 Lakeland Drive
Jackson, Mississippi 39216
(more details on this long term acute care hospital)

Regency Hospital of Meridian
Long Term Acute Care Hospital
1102 Constitution Avenue, 2nd Floor
Meridian, Mississippi 39301
(more details on this long term acute care hospital)

Restorative Care Hospital
Long Term Acute Care Hospital
1225 North State Street
Jackson, Mississippi 39202
(more details on this long term acute care hospital)

Rush Foundation Hospital
Long Term Acute Care Hospital
1314 19th Avenue
Meridian, Mississippi 39301
(more details on this long term acute care hospital)

Rush Foundation Hospital
Long Term Acute Care Hospital
1314 19th Avenue
Meridian, Mississippi 39301
(more details on this long term acute care hospital)

(more details on this long term acute care hospital)

Select Specialty Hospital - Gulf Coast

Long Term Acute Care Hospital
1520 Broad Avenue
Gulfport, Mississippi 39501
(more details on this long term acute care hospital)

Select Specialty Hospital - Jackson

Long Term Acute Care Hospital
5903 Ridgewood Road
Jackson, Mississippi 39211
(more details on this long term acute care hospital)

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Filter By Missouri Provider Type

Missouri Adult Day Care Center
Missouri Alzheimers Center
Missouri Assisted Living
Missouri Behavioral Health Center
Missouri Dialysis Center
Missouri Home Dialysis
Missouri DME Dialysis
Missouri Durable Medical Equipment General
Missouri Durable Medical Equipment Nutrition
Missouri DME Oxygen
Missouri Home Health Care
Missouri Hospice Care Center
Missouri Hospice Service
Missouri Acute Care Hospital
Missouri Long Term Acute Care Hospital
Missouri Intermediate Care Facility
Missouri IV Infusion
Missouri Long Term Respiratory Care
Missouri Neurology Clinic
Missouri Nursing Home
Missouri Personal Care Home
Missouri Outpatient Rehab
Missouri Inpatient Rehabilitation Facility
Missouri Nursing Home Rehabilitation
Missouri Respiratory Therapy Agency
Missouri Sleep Disorder Clinic
Missouri Medical Transport Service

Missouri Long Term Acute Care Hospital Directory

Dubuis Hospital - St. Louis
Long Term Acute Care Hospital
13190 South Outer 40 Road
Chesterfield, Missouri 63017
(more details on this long term acute care hospital)

Kindred Hospital - Kansas City
Long Term Acute Care Hospital
8701 Troost Avenue
Kansas City, Missouri 64131
(more details on this long term acute care hospital)

Kindred Hospital - St. Louis
Long Term Acute Care Hospital
4930 Lindell Boulevard
St. Louis, Missouri 63108
(more details on this long term acute care hospital)

Landmark Hospital Of Cape Girardeau
Long Term Acute Care Hospital
3255 Independence
Cape Girardeau, Missouri 63703
(more details on this long term acute care hospital)

Missouri Rehabilitation Center
Long Term Acute Care Hospital
600 North Main Street
Mount Vernon, Missouri 65712
(more details on this long term acute care hospital)

Select Specialty Hospital - St. Louis
Long Term Acute Care Hospital
6150 Oakland Avenue 5Th Floor
St. Louis, Missouri 63139
(more details on this long term acute care hospital)

Select Specialty Hospital - Western Missouri
Long Term Acute Care Hospital
2316 East Meyer Boulevard, 3-West
Kansas City, Missouri 64132
(more details on this long term acute care hospital)

Shelby County, Tennessee

People QuickFacts	Shelby County	Tennessee
Population, 2011 estimate	935,088	6,403,353
Population, 2010 (April 1) estimates base	927,644	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	0.8%	0.9%
Population, 2010	927,644	6,346,105
Persons under 5 years, percent, 2011	7.2%	6.3%
Persons under 18 years, percent, 2011	26.1%	23.3%
Persons 65 years and over, percent, 2011	10.4%	13.7%
Female persons, percent, 2011	52.3%	51.3%
White persons, percent, 2011 (a)	43.6%	79.5%
Black persons, percent, 2011 (a)	52.3%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.4%	0.4%
Asian persons, percent, 2011 (a)	2.4%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.3%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	5.8%	4.7%
White persons not Hispanic, percent, 2011	38.6%	75.4%
Living in same house 1 year & over, percent, 2007-2011	82.0%	84.1%
Foreign born persons, percent, 2007-2011	6.0%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	8.6%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	85.5%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	28.3%	23.0%
Veterans, 2007-2011	61,732	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	22.3	24.0
Housing units, 2011	397,976	2,829,025
Homeownership rate, 2007-2011	60.8%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	27.7%	18.1%
Median value of owner-occupied housing units, 2007-2011	$136,200	$137,200
Households, 2007-2011	340,394	2,457,997
Persons per household, 2007-2011	2.66	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$25,470	$24,197
Median household income, 2007-2011	$46,102	$43,989
Persons below poverty level, percent, 2007-2011	20.1%	16.9%

Business QuickFacts	Shelby County	Tennessee
Private nonfarm establishments, 2010	20,038	131,582[1]
Private nonfarm employment, 2010	419,469	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-12.1	-5.3[1]
Nonemployer establishments, 2010	77,496	465,545
Total number of firms, 2007	76,350	545,348
Black-owned firms, percent, 2007	30.9%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.3%	0.5%
Asian-owned firms, percent, 2007	3.4%	2.0%

Dyer County, Tennessee

People QuickFacts	Dyer County	Tennessee
Population, 2011 estimate	38,192	6,403,353
Population, 2010 (April 1) estimates base	38,335	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	-0.4%	0.9%
Population, 2010	38,335	6,346,105
Persons under 5 years, percent, 2011	6.5%	6.3%
Persons under 18 years, percent, 2011	24.7%	23.3%
Persons 65 years and over, percent, 2011	14.8%	13.7%
Female persons, percent, 2011	51.8%	51.3%
White persons, percent, 2011 (a)	83.1%	79.5%
Black persons, percent, 2011 (a)	14.4%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.3%	0.4%
Asian persons, percent, 2011 (a)	0.5%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	0.1%
Persons reporting two or more races, percent, 2011	1.7%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	2.7%	4.7%
White persons not Hispanic, percent, 2011	80.8%	75.4%
Living in same house 1 year & over, percent, 2007-2011	81.4%	84.1%
Foreign born persons, percent, 2007-2011	1.3%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	2.4%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	80.6%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	15.8%	23.0%
Veterans, 2007-2011	3,138	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	17.6	24.0
Housing units, 2011	16,651	2,829,025
Homeownership rate, 2007-2011	64.7%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	14.6%	18.1%
Median value of owner-occupied housing units, 2007-2011	$93,700	$137,200
Households, 2007-2011	15,283	2,457,997
Persons per household, 2007-2011	2.46	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$20,367	$24,197
Median household income, 2007-2011	$38,909	$43,989
Persons below poverty level, percent, 2007-2011	19.2%	16.9%

Business QuickFacts	Dyer County	Tennessee
Private nonfarm establishments, 2010	818	131,582[1]
Private nonfarm employment, 2010	13,018	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-13.8	-5.3[1]
Nonemployer establishments, 2010	2,447	465,545
Total number of firms, 2007	3,139	545,348
Black-owned firms, percent, 2007	S	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	S	0.5%
Asian-owned firms, percent, 2007	F	2.0%

Fayette County, Tennessee

People QuickFacts	Fayette County	Tennessee
Population, 2011 estimate	38,513	6,403,353
Population, 2010 (April 1) estimates base	38,413	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	0.3%	0.9%
Population, 2010	38,413	6,346,105
Persons under 5 years, percent, 2011	6.3%	6.3%
Persons under 18 years, percent, 2011	22.6%	23.3%
Persons 65 years and over, percent, 2011	15.5%	13.7%
Female persons, percent, 2011	50.3%	51.3%
White persons, percent, 2011 (a)	70.3%	79.5%
Black persons, percent, 2011 (a)	28.0%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.3%	0.4%
Asian persons, percent, 2011 (a)	0.6%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	0.1%
Persons reporting two or more races, percent, 2011	0.8%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	2.4%	4.7%
White persons not Hispanic, percent, 2011	68.2%	75.4%
Living in same house 1 year & over, percent, 2007-2011	92.2%	84.1%
Foreign born persons, percent, 2007-2011	1.9%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	3.8%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	84.1%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	20.4%	23.0%
Veterans, 2007-2011	2,820	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	32.5	24.0
Housing units, 2011	15,874	2,829,025
Homeownership rate, 2007-2011	82.6%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	4.9%	18.1%
Median value of owner-occupied housing units, 2007-2011	$176,600	$137,200
Households, 2007-2011	13,825	2,457,997
Persons per household, 2007-2011	2.72	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$28,606	$24,197
Median household income, 2007-2011	$57,437	$43,989
Persons below poverty level, percent, 2007-2011	11.7%	16.9%

Business QuickFacts	Fayette County	Tennessee
Private nonfarm establishments, 2010	550	131,582[1]
Private nonfarm employment, 2010	6,094	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	44.7	-5.3[1]
Nonemployer establishments, 2010	3,055	465,545
Total number of firms, 2007	3,779	545,348
Black-owned firms, percent, 2007	15.3%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	S	2.0%

Gibson County, Tennessee

People QuickFacts	Gibson County	Tennessee
Population, 2011 estimate	49,935	6,403,353
Population, 2010 (April 1) estimates base	49,683	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	0.5%	0.9%
Population, 2010	49,683	6,346,105
Persons under 5 years, percent, 2011	6.4%	6.3%
Persons under 18 years, percent, 2011	24.7%	23.3%
Persons 65 years and over, percent, 2011	16.6%	13.7%
Female persons, percent, 2011	52.4%	51.3%
White persons, percent, 2011 (a)	79.4%	79.5%
Black persons, percent, 2011 (a)	18.9%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.2%	0.4%
Asian persons, percent, 2011 (a)	0.3%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	0.1%
Persons reporting two or more races, percent, 2011	1.2%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	2.1%	4.7%
White persons not Hispanic, percent, 2011	77.6%	75.4%
Living in same house 1 year & over, percent, 2007-2011	83.4%	84.1%
Foreign born persons, percent, 2007-2011	0.9%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	3.3%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	80.9%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	15.2%	23.0%
Veterans, 2007-2011	3,719	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	23.1	24.0
Housing units, 2011	22,012	2,829,025
Homeownership rate, 2007-2011	71.1%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	11.0%	18.1%
Median value of owner-occupied housing units, 2007-2011	$86,900	$137,200
Households, 2007-2011	19,452	2,457,997
Persons per household, 2007-2011	2.49	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$20,415	$24,197
Median household income, 2007-2011	$37,577	$43,989
Persons below poverty level, percent, 2007-2011	17.9%	16.9%

Business QuickFacts	Gibson County	Tennessee
Private nonfarm establishments, 2010	935	131,582[1]
Private nonfarm employment, 2010	11,638	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-29.2	-5.3[1]
Nonemployer establishments, 2010	2,837	465,545
Total number of firms, 2007	3,423	545,348
Black-owned firms, percent, 2007	S	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	S	2.0%

Lauderdale County, Tennessee

People QuickFacts	Lauderdale County	Tennessee
Population, 2011 estimate	27,748	6,403,353
Population, 2010 (April 1) estimates base	27,815	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	-0.2%	0.9%
Population, 2010	27,815	6,346,105
Persons under 5 years, percent, 2011	6.4%	6.3%
Persons under 18 years, percent, 2011	23.8%	23.3%
Persons 65 years and over, percent, 2011	12.7%	13.7%
Female persons, percent, 2011	47.5%	51.3%
White persons, percent, 2011 (a)	63.0%	79.5%
Black persons, percent, 2011 (a)	34.9%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.7%	0.4%
Asian persons, percent, 2011 (a)	0.3%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	0.1%
Persons reporting two or more races, percent, 2011	1.1%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	2.1%	4.7%
White persons not Hispanic, percent, 2011	61.4%	75.4%
Living in same house 1 year & over, percent, 2007-2011	78.9%	84.1%
Foreign born persons, percent, 2007-2011	1.7%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	2.7%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	74.5%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	10.2%	23.0%
Veterans, 2007-2011	1,906	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	23.0	24.0
Housing units, 2011	11,221	2,829,025
Homeownership rate, 2007-2011	65.8%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	12.4%	18.1%
Median value of owner-occupied housing units, 2007-2011	$78,100	$137,200
Households, 2007-2011	9,577	2,457,997
Persons per household, 2007-2011	2.61	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$16,321	$24,197
Median household income, 2007-2011	$34,078	$43,989
Persons below poverty level, percent, 2007-2011	25.3%	16.9%

Business QuickFacts	Lauderdale County	Tennessee
Private nonfarm establishments, 2010	316	131,582[1]
Private nonfarm employment, 2010	4,449	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-33.2	-5.3[1]
Nonemployer establishments, 2010	1,326	465,545
Total number of firms, 2007	1,446	545,348
Black-owned firms, percent, 2007	6.2%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	F	2.0%

Madison County, Tennessee

People QuickFacts	Madison County	Tennessee
Population, 2011 estimate	98,255	6,403,353
Population, 2010 (April 1) estimates base	98,294	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	Z	0.9%
Population, 2010	98,294	6,346,105
Persons under 5 years, percent, 2011	6.8%	6.3%
Persons under 18 years, percent, 2011	23.7%	23.3%
Persons 65 years and over, percent, 2011	13.5%	13.7%
Female persons, percent, 2011	52.5%	51.3%
White persons, percent, 2011 (a)	61.0%	79.5%
Black persons, percent, 2011 (a)	36.4%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.3%	0.4%
Asian persons, percent, 2011 (a)	1.0%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	0.1%
Persons reporting two or more races, percent, 2011	1.3%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	3.5%	4.7%
White persons not Hispanic, percent, 2011	58.0%	75.4%
Living in same house 1 year & over, percent, 2007-2011	84.9%	84.1%
Foreign born persons, percent, 2007-2011	3.4%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	4.8%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	84.9%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	24.0%	23.0%
Veterans, 2007-2011	7,035	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	19.3	24.0
Housing units, 2011	41,842	2,829,025
Homeownership rate, 2007-2011	66.7%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	19.8%	18.1%
Median value of owner-occupied housing units, 2007-2011	$112,400	$137,200
Households, 2007-2011	36,188	2,457,997
Persons per household, 2007-2011	2.59	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$23,186	$24,197
Median household income, 2007-2011	$40,667	$43,989
Persons below poverty level, percent, 2007-2011	19.2%	16.9%

Business QuickFacts	Madison County	Tennessee
Private nonfarm establishments, 2010	2,568	131,582[1]
Private nonfarm employment, 2010	48,918	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-8.1	-5.3[1]
Nonemployer establishments, 2010	6,336	465,545
Total number of firms, 2007	8,412	545,348
Black-owned firms, percent, 2007	14.1%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	S	0.5%
Asian-owned firms, percent, 2007	1.9%	2.0%

McNairy County, Tennessee

People QuickFacts	McNairy County	Tennessee
Population, 2011 estimate	26,094	6,403,353
Population, 2010 (April 1) estimates base	26,075	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	0.1%	0.9%
Population, 2010	26,075	6,346,105
Persons under 5 years, percent, 2011	5.8%	6.3%
Persons under 18 years, percent, 2011	23.0%	23.3%
Persons 65 years and over, percent, 2011	17.7%	13.7%
Female persons, percent, 2011	50.9%	51.3%
White persons, percent, 2011 (a)	92.1%	79.5%
Black persons, percent, 2011 (a)	6.1%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.3%	0.4%
Asian persons, percent, 2011 (a)	0.2%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	0.1%
Persons reporting two or more races, percent, 2011	1.2%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	1.6%	4.7%
White persons not Hispanic, percent, 2011	90.8%	75.4%
Living in same house 1 year & over, percent, 2007-2011	92.1%	84.1%
Foreign born persons, percent, 2007-2011	1.1%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	3.3%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	76.1%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	11.8%	23.0%
Veterans, 2007-2011	2,243	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	22.8	24.0
Housing units, 2011	11,953	2,829,025
Homeownership rate, 2007-2011	76.0%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	4.1%	18.1%
Median value of owner-occupied housing units, 2007-2011	$85,100	$137,200
Households, 2007-2011	10,057	2,457,997
Persons per household, 2007-2011	2.53	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$18,891	$24,197
Median household income, 2007-2011	$34,953	$43,989
Persons below poverty level, percent, 2007-2011	22.5%	16.9%

Business QuickFacts	McNairy County	Tennessee
Private nonfarm establishments, 2010	442	131,582[1]
Private nonfarm employment, 2010	4,609	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-50.0	-5.3[1]
Nonemployer establishments, 2010	1,761	465,545
Total number of firms, 2007	1,855	545,348
Black-owned firms, percent, 2007	F	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	F	2.0%

Tipton County, Tennessee

People QuickFacts	Tipton County	Tennessee
Population, 2011 estimate	61,293	6,403,353
Population, 2010 (April 1) estimates base	61,081	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	0.3%	0.9%
Population, 2010	61,081	6,346,105
Persons under 5 years, percent, 2011	6.4%	6.3%
Persons under 18 years, percent, 2011	26.9%	23.3%
Persons 65 years and over, percent, 2011	11.4%	13.7%
Female persons, percent, 2011	51.0%	51.3%
White persons, percent, 2011 (a)	78.3%	79.5%
Black persons, percent, 2011 (a)	18.9%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.4%
Asian persons, percent, 2011 (a)	0.6%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.7%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	2.3%	4.7%
White persons not Hispanic, percent, 2011	76.4%	75.4%
Living in same house 1 year & over, percent, 2007-2011	85.4%	84.1%
Foreign born persons, percent, 2007-2011	1.6%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	2.4%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	84.1%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	13.5%	23.0%
Veterans, 2007-2011	5,388	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	31.5	24.0
Housing units, 2011	23,436	2,829,025
Homeownership rate, 2007-2011	73.5%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	7.4%	18.1%
Median value of owner-occupied housing units, 2007-2011	$137,400	$137,200
Households, 2007-2011	21,578	2,457,997
Persons per household, 2007-2011	2.76	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$22,062	$24,197
Median household income, 2007-2011	$50,869	$43,989
Persons below poverty level, percent, 2007-2011	15.3%	16.9%

Business QuickFacts	Tipton County	Tennessee
Private nonfarm establishments, 2010	750	131,582[1]
Private nonfarm employment, 2010	8,189	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-15.7	-5.3[1]
Nonemployer establishments, 2010	3,822	465,545
Total number of firms, 2007	3,817	545,348
Black-owned firms, percent, 2007	9.4%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	S	2.0%

TennCare Enrollment Data for August 2012

MCO	REGION	Total
Amerigroup	Middle Tennessee	200,096
BlueCare	East Tennessee	218,391
BlueCare	West Tennessee	180,405
TennCare Select	All	46,926
United HealthCare	East Tennessee	194,457
United HealthCare	Middle Tennessee	200,602
United HealthCare	West Tennessee	174,750
Unknown	Unknown	1,838
Grand Total		1,217,466

	Female					Male					
COUNTY	0 - 18	19 - 20	21 - 64	65 -->	Female Total	0 - 18	19 - 20	21 - 64	65 -->	Male Total	Grand Total
ANDERSON	3,756	305	3,322	620	8,003	3,963	218	1,621	276	6,078	14,081
BEDFORD	3,290	251	2,159	252	5,952	3,379	144	971	109	4,604	10,555
BENTON	888	80	769	154	1,891	980	46	453	69	1,548	3,439
BLEDSOE	737	59	625	122	1,543	812	59	358	54	1,282	2,825
BLOUNT	5,220	443	4,420	691	10,774	5,274	281	2,033	296	7,885	18,659
BRADLEY	5,026	476	4,447	646	10,594	5,405	295	2,006	270	7,976	18,570
CAMPBELL	2,729	256	3,102	666	6,754	2,868	203	1,746	393	5,210	11,964
CANNON	710	68	600	131	1,510	793	47	325	56	1,221	2,730
CARROLL	1,700	139	1,577	342	3,759	1,839	110	794	145	2,889	6,648
CARTER	2,961	252	2,586	716	6,515	3,190	165	1,366	269	4,990	11,505
CHEATHAM	1,800	135	1,408	182	3,525	1,868	110	647	74	2,699	6,224
CHESTER	940	89	820	156	2,005	961	57	330	66	1,415	3,420
CLAIBORNE	1,880	160	1,861	545	4,446	1,935	118	1,174	253	3,481	7,927
CLAY	517	35	422	109	1,083	507	34	271	80	892	1,975
COCKE	2,547	231	2,340	464	5,581	2,601	163	1,330	224	4,318	9,899
COFFEE	3,180	263	2,652	380	6,475	3,258	151	1,165	167	4,740	11,215
CROCKETT	976	88	711	209	1,984	975	50	338	82	1,445	3,429
CUMBERLAND	2,865	226	2,318	502	5,911	2,979	185	1,157	235	4,556	10,467
DAVIDSON	36,418	2,606	27,311	3,260	69,595	37,665	1,777	10,163	1,467	51,073	120,668
DECATUR	577	62	530	193	1,363	673	41	300	74	1,088	2,451
DEKALB	1,161	73	988	196	2,418	1,255	61	535	87	1,938	4,356
DICKSON	2,555	167	2,159	322	5,203	2,645	136	915	94	3,790	8,993
DYER	2,566	218	2,308	423	5,515	2,678	146	981	146	3,952	9,467
FAYETTE	1,590	143	1,197	299	3,229	1,716	90	535	117	2,458	5,686
FENTRESS	1,290	110	1,256	378	3,034	1,396	90	804	184	2,474	5,508
FRANKLIN	1,782	160	1,516	283	3,740	1,851	82	712	109	2,753	6,493
GIBSON	2,925	251	2,596	655	6,427	3,090	212	1,112	274	4,688	11,115
GILES	1,446	139	1,250	271	3,106	1,486	85	661	113	2,344	5,450
GRAINGER	1,332	101	1,098	299	2,830	1,300	63	648	155	2,167	4,997
GREENE	3,300	258	3,076	728	7,362	3,395	176	1,674	358	5,603	12,966
GRUNDY	1,110	119	1,084	217	2,530	1,188	87	605	132	2,012	4,541
HAMBLEN	3,929	253	2,748	598	7,528	3,964	164	1,221	221	5,570	13,098
HAMILTON	15,370	1,232	13,585	2,299	32,486	16,108	811	5,343	824	23,087	55,573
HANCOCK	480	50	521	171	1,222	571	37	314	81	1,003	2,225
HARDEMAN	1,648	147	1,557	353	3,704	1,611	111	733	159	2,615	6,319
HARDIN	1,604	152	1,452	392	3,600	1,661	106	763	199	2,729	6,329
HAWKINS	3,057	297	2,821	568	6,743	3,228	164	1,444	267	5,103	11,847
HAYWOOD	1,423	138	1,312	304	3,177	1,517	95	401	112	2,125	5,301
HENDERSON	1,672	135	1,456	273	3,536	1,669	92	668	102	2,531	6,067

TennCare Enrollment Data for August 2012

HENRY	1,927	164	1,610	303	4,004	2,014	126	755	117	3,011	7,015
HICKMAN	1,432	130	1,290	178	3,030	1,552	103	668	84	2,408	5,437
HOUSTON	426	47	385	114	973	490	29	203	71	793	1,766
HUMPHREYS	947	81	813	157	1,998	957	48	393	69	1,466	3,464
JACKSON	641	43	611	153	1,449	655	32	352	95	1,133	2,582
JEFFERSON	2,847	202	2,223	531	5,802	2,882	141	1,102	193	4,318	10,119
JOHNSON	952	82	893	293	2,220	932	81	566	159	1,738	3,958
KNOX	17,545	1,334	15,673	2,409	36,960	18,214	886	6,542	961	26,603	63,563
LAKE	423	40	521	162	1,147	500	33	223	68	824	1,971
LAUDERDALE	1,983	171	1,828	323	4,304	2,046	127	724	124	3,021	7,326
LAWRENCE	2,337	174	1,986	413	4,910	2,527	140	939	165	3,771	8,681
LEWIS	692	59	581	130	1,462	762	42	270	60	1,134	2,596
LINCOLN	1,801	163	1,404	330	3,698	1,876	100	710	127	2,813	6,511
LOUDON	2,107	146	1,537	305	4,096	2,085	98	698	120	3,001	7,097
MACON	1,588	147	1,308	259	3,301	1,700	88	674	108	2,570	5,871
MADISON	6,023	531	5,387	826	12,767	5,979	312	1,776	327	8,394	21,161
MARION	1,659	175	1,593	270	3,696	1,661	103	682	140	2,585	6,282
MARSHALL	1,599	140	1,304	180	3,223	1,708	72	567	65	2,412	5,635
MAURY	4,248	323	3,538	568	8,677	4,554	250	1,349	199	6,352	15,029
MCMINN	2,771	248	2,468	536	6,023	2,948	175	1,163	226	4,512	10,535
MCNAIRY	1,722	171	1,666	410	3,968	1,777	141	927	204	3,049	7,017
MEIGS	755	64	636	86	1,540	724	47	324	49	1,145	2,685
MONROE	2,542	221	2,211	519	5,493	2,782	148	1,167	247	4,344	9,837
MONTGOMERY	6,983	572	5,793	652	14,000	7,225	302	1,804	220	9,551	23,552
MOORE	234	24	154	53	464	265	8	101	14	388	852
MORGAN	1,119	93	902	194	2,307	1,181	71	528	104	1,883	4,190
OBION	1,794	160	1,563	311	3,827	1,898	79	581	107	2,665	6,492
OUT-OF-ST CO	704	133	1,574	182	2,593	969	113	1,094	117	2,292	4,885
OUT-OF-ST NO	2		17	4	23	2		18		20	43
OVERTON	1,132	86	934	284	2,436	1,246	61	532	141	1,981	4,417
PERRY	515	39	381	90	1,025	524	29	215	44	812	1,837
PICKETT	224	20	188	97	529	280	12	122	47	461	990
POLK	917	57	857	156	1,987	956	50	457	80	1,543	3,530
PUTNAM	3,747	374	3,275	770	8,167	3,932	231	1,724	323	6,210	14,376
RHEA	2,230	180	1,802	353	4,564	2,264	133	867	138	3,402	7,966
ROANE	2,357	200	2,378	559	5,495	2,695	145	1,303	230	4,374	9,869
ROBERTSON	3,577	233	2,357	385	6,552	3,687	136	971	164	4,958	11,510
RUTHERFORD	11,385	950	8,021	1,004	21,360	11,857	601	2,880	365	15,703	37,063
SCOTT	1,847	171	1,705	412	4,134	1,870	127	975	194	3,167	7,301
SEQUATCHIE	921	86	765	146	1,918	966	48	438	63	1,515	3,432
SEVIER	4,814	328	3,154	460	8,756	5,110	199	1,253	176	6,738	15,494
SHELBY	69,355	6,442	55,837	6,601	138,236	70,997	4,453	15,908	2,395	93,753	231,988
SMITH	1,027	83	896	186	2,193	1,037	67	409	69	1,581	3,774
STEWART	694	55	638	121	1,508	707	28	322	56	1,113	2,622
SULLIVAN	7,098	614	6,751	1,366	15,829	7,391	405	3,361	617	11,774	27,603
SUMNER	6,703	552	5,363	810	13,427	7,122	353	2,083	307	9,865	23,292
TIPTON	3,422	336	2,599	375	6,733	3,627	208	900	147	4,882	11,615
TROUSDALE	461	35	369	81	947	468	32	182	40	721	1,668
UNICOI	913	77	810	285	2,085	986	55	376	125	1,541	3,626
UNION	1,271	100	917	167	2,456	1,308	73	523	88	1,992	4,448
VAN BUREN	296	26	261	59	643	336	14	159	46	554	1,197
WARREN	2,520	178	2,151	454	5,304	2,664	138	1,065	182	4,049	9,354
WASHINGTON	4,875	444	4,866	995	11,181	5,062	304	2,253	392	8,011	19,192

TennCare Enrollment Data for August 2012

WAYNE	774	60	651	174	1,659	841	38	343	84	1,306	2,965
WEAKLEY	1,692	217	1,497	313	3,719	1,746	124	721	116	2,708	6,427
WHITE	1,533	123	1,280	339	3,276	1,646	92	746	122	2,605	5,881
WILLIAMSON	2,633	191	1,725	350	4,900	2,818	133	706	112	3,770	8,670
WILSON	4,084	312	3,270	507	8,173	4,281	206	1,378	186	6,051	14,225
Grand Total	**341,778**	**28,773**	**285,128**	**48,116**	**703,795**	**355,546**	**19,453**	**118,685**	**19,985**	**513,670**	**1,217,465**

...SUCCESSOR BY ...ER TO WELLS ...O BANK MINNE... ...NATIONAL ASSO... ...ON, SOLELY IN ITS ...ITY AS TRUSTEE ...ROVIDENT BANK ... EQUITY LOAN ...-BACKED CER... ...TES, SERIES 2000... ...er), now being the ...owner/holder of ...ndebtedness, has ...quested that fore... ...proceedings be in... ...d said Holder ...ppointed the firm ...elow as Successor ...under said Deed ...t, by an instrument ...corded in the afore... ...cords, to serve in ...e end stead of the ...entioned Trustee, ...of the Right to ...ose was sent to the ...er by letter dated ...26, 2012.

...HEREFORE, said ...or Trustee, or ...hereof, pursuant to ...ed of Trust, having ...equested by the ...o to do, and by vir... ...the authority and ...ested in said Suc... ...Trustee by said ...Trust, will on Jan... ...2013 at 1:00 p.m., at ...al and customary ... at the Shelby ...Tennessee, Court... ...ell at public outcry ...ighest bidder for ...credit upon the in... ...ess secured if the ...wner and holder ...is the successful ...er), the following... ...d property:

...RTHEAST ONE ...TRACT OF THE ...V. GRAY AND J.C. ...ET 14.5 ACRE ...ON OLD ARLING... ...KE SECTION 3, ... 4, SHELBY ..., TENNESSEE ...ING MORE PAR... ...RLY DE... ...D BY METES ...UNDS AS FOL...

Notice of the Right to Foreclose was sent to the Borrower by letter dated August 21, 2012.

NOW, THEREFORE, said Successor Trustee, or agent thereof, pursuant to said Deed of Trust, having been requested by the Holder so to do, and by virtue of the authority and power vested in said Successor Trustee by said Deed of Trust, will on January 02, 2013 at 1:00 p.m., at the usual and customary location at the Madison County, Tennessee, Courthouse, sell at public outcry to the highest bidder for cash (or credit upon the indebtedness secured if the lawful owner and holder thereof is the successful purchaser), the following-described property:

SITUATED IN THE 5TH CIVIL DISTRICT OF MADISON COUNTY, TENNESSEE, AND BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT A STAKE IN THE SOUTHERLY MARGIN OF LANWAY COVE AT THE NORTH-EAST CORNER OF LOT NO.50 IN SECTION IV OF LANDMARK ESTATES, A PLAT OF WHICH APPEARS OF RECORD IN PLAT BOOK 3, PAGE 98, REGISTER'S OFFICE OF MADISON COUNTY, TENNESSEE; RUNS THENCE SOUTH 40 DEG. 14.9 MIN. WEST WITH THE EASTERLY MARGIN OF SAID LOT NO. 50 A DISTANCE OF 183.9 FEET, MORE OR LESS, TO A STAKE; THENCE SOUTH 24 DEG. 13.5 MIN. EAST A DISTANCE OF 110 FEET TO A CONCRETE CORNER MARKER; THENCE NORTH 37 DEG. 47 MIN. EAST, WITH THE WESTERLY LINE OF SAID LOT NO.52 A DISTANCE OF 343.1 FEET TO

COUNTY, TENNESSEE.

BEING THE SAME PROPERTY CONVEYED TO INGLEWOOD HOMES, LLC BY WARRANTY DEED FROM MIKE MURPHY BUILDERS, LLC, A TENNESSEE LIMITED LIABILITY COMPANY, DATED 7/15/05 AND RECORDED 8/3/05 OF RECORD AT INSTRUMENT NO. 05123688, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE.

BEING THE SAME PROPERTY CONVEYED TO FRANK R. PRESLEY D/B/A PRESLEY HOMES BY WARRANTY DEED FROM INGLEWOOD HOMES, LLC, DATED 2/10/06 AND RECORDED 2/20/06 OF RECORD AT INSTRUMENT NO. 06028260, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE.

BEING THE SAME PROPERTY CONVEYED TO RAY MADISON AND TAMEKA MADISON, MARRIED BY WARRANTY DEED FROM FRANK R. PRESLEY D/B/A PRESLEY HOMES, DATED 11/29/06 AND RECORDED 12.5.06 OF RECORD AT INSTRUMENT NO.06197117, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE.

For informational purposes only, this property is commonly known as 4485 Whisperwood Drive, Collierville, TN 38017, Parcel ID C0258Z C00042.

The property shall be free from all right and equity of redemption, statutory or otherwise, homestead, dower, courtesy, elective share, and all other exemptions that are expressly waived in said Deed of Trust, and the title is believed to be good, but the Successor Trustee will sell and convey only as Successor Trustee, "as is" and "where is" and without covenants of seizing or warranties of title.

Listing of Subordinate Lienholders: N/A

Listing of Other Interested Parties: N/A

This sale is subject to liens; easements; encumbrances; property taxes; rights of redemption of taxing entities; all matters shown on any recorded plan(s) or plat(s); any unpaid taxes; any restrictive covenants, easements or setback lines that may be applicable; any statutory rights of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; any matter that an accurate survey of the premises might disclose; and other matters which are prior in right to the lien of the aforesaid Deed of Trust.

If a high bidder fails to close a sale, the Successor Trustee shall have the option of making the sale to the next highest bidder. The sale held pursuant to this Notice may be rescinded at the Successor Trustee's option at any time. The right is reserved to adjourn the sale to another day, time and/or place certain without further publication, upon announcement at the time and place for the sale set forth above, or at any date and time fixed by a preceding postponement. Alternatively, at its option, Successor Trustee may

Successor Trustee may give a new notice of sale.

Weissman Nowack Curry & Wilco, PC

One Alliance Center

File #: 013535

NOTIFICATION OF INTENT TO APPLY FOR A Certificate of Need

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that Spasit Health Care Associates, P.C. ("Applicant"), 8132 Cordova Road, Suite 101, Cordova, TN 38106, owned by Rick Worster, D.C., 8132 Cordova Road, Suite 102, Cordova, TN 38108, and managed by itself, intends to file an application for a Certificate of Need for establishment of a specialty ambulatory surgical treatment center ("ASTC") providing only manipulation under anesthesia ("MUA") services. This new ASTC will be located in an existing building, and will have one (1) procedure room, one (1) exam room, one (1) recovery room, along with other related space. The Applicant will provide only MUA and related services, which are manual surgical procedures, and no operative surgical procedures will be performed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that the specialty ASTC will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $474,667, which includes the cost of the filing fee.

The anticipated date of filing the application is: December 14, 2012.

The contact person for this project is E. Graham Baker, Jr., Attorney who may be reached at 2021 Richard Jones Road, Suite 350, Nashville, TN 37215, 615/370-3380.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Instrument 06004523, Register's Office for Madison County, Tennessee, from

ing the present owner/holder of said Indebtedness, has now re-

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Select Specialty Hospital-Memphis (a long term acute care hospital), owned and managed by Select Specialty Hospital-Memphis, Inc. (a corporation), intends to file an application for a Certificate of Need to add twenty-eight (28) long term acute care beds to its facility, located in leased space at St. Francis Hospital, 5959 Park Avenue, Memphis, TN 38119. The project cost for CON purposes is estimated at $6,900,000. The project contains no major medical equipment and does not add or discontinue any new health service.

Select Specialty Hospital is currently licensed by the Board for Licensing Healthcare Facilities (TN Department of Public Health) for thirty-nine (39) long term acute care beds. Select Specialty has received State approval for licensure of ten (10) additional long term acute care beds without CON review, under a statutory exemption available to hospitals of fewer than 100 beds. Upon its implementation, Select will be licensed for forty-nine (49) long term acute care beds, so that the twenty-eight (28) bed expansion proposed in this Certificate of Need application would increase the Select license to seventy-seven (77) long term acute care beds. St. Francis Hospital, which is leasing these beds to Select, will reduce its current 519-bed general hospital license by 10 beds to reflect the approved 10-bed expansion of Select through the CON exemption process, and will reduce its license by 28 more beds if this CON application is approved. The net effect of these changes will be that the project will not change the service area's total licensed complement of general acute care plus long term acute care hospital beds.

The anticipated date of filing the application is on or before December 14, 2012. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency, Andrew Jackson Building, 500 Deaderick Street, Suite 850, Nashville, Tennessee 37243

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

May 1, 2013

John L. Wellborn, Consultant
Development Support Group
4219 Hillsboro Road, Suite 203
Nashville, TN 37215

RE: Select Specialty Hospital-Memphis - Certificate of Need CN1212-062
Addition of 28 long term acute care beds to the existing 39-bed facility located in leased space in St. Francis Hospital. With the addition of the 28 beds and the 10 beds added per the statutory exemption found at TCA § 68-11-107 (g), the licensed bed complement will increase to 77 beds. St. Francis will delicense 38 beds.

Dear Mr. Wellborn:

This is to notify you that the referenced application is scheduled to be acted upon by the Agency at its next monthly meeting in Nashville on Wednesday, May 22, 2013, beginning at 8:30 A.M. The meeting will be held at the following location:

Legislative Plaza, Room 12
Sixth Avenue North & Union Street
Nashville, TN

Please be present and prepared to make a brief presentation and to respond to any questions regarding the application. Your presentation should address the following:

- Why the project is needed to provide necessary health care in the service area;
- How it can be economically accomplished and maintained; and,
- Its contribution to the orderly development of adequate and effective health care facilities and/or services.

In its review of the project, the Agency will weigh and consider the health care needs of consumers, particularly women, racial and ethnic minorities, TennCare or Medicaid recipients and low income groups. The applicant's current and future commitment to TennCare and any contractual agreements should be disclosed if applicable to the type facility or service sought.

Should you desire that Agency members receive information that has not been previously submitted, please forward twenty-four (24) copies of the information to this office by noon on **May 8, 2013.**

Meeting procedure information is enclosed for your review. Please call if you have any questions.

Sincerely,

Melanie M. Hill
Executive Director

MMH/as
Enclosure

HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
MAY 22, 2013
APPLICATION SUMMARY

NAME OF PROJECT:	Select Specialty Hospital-Memphis
PROJECT NUMBER:	CN1212-062
ADDRESS:	5959 Park Avenue Memphis (Shelby County), TN 38119
LEGAL OWNER:	Select Specialty Hospital-Memphis, Inc. 5959 Park Avenue Memphis (Shelby County), TN 38119
OPERATING ENTITY:	N/A
CONTACT PERSON:	John Wellborn (615) 665-2022
DATE FILED:	December 14, 2012
PROJECT COST:	$6,898,392
FINANCING:	Cash Reserves
REASON FOR FILING:	Addition of twenty-eight (28) long term acute care hospital (LTACH) beds to its current LTACH

DESCRIPTION:

Select Specialty Hospital-Memphis is seeking approval for the addition of twenty-eight (28) long-term acute care beds to its current thirty-nine (39) bed LTACH located within St Francis Hospital. The applicant is also in the process of adding ten (10) beds pursuant to TCA 68-11-1607(8)(g) which permits a hospital with fewer than 100 beds to increase its total number of licensed beds by ten beds over any one year period without obtaining a Certificate of Need.. If approved, the final bed count for the facility will be seventy-seven (77) LTACH beds.

SPECIFIC CRITERIA AND STANDARDS REVIEW:

LONG TERM CARE HOSPITAL BEDS

A. Need

1. The need for long term care hospital (LTH) beds shall be determined by applying the guidelines of (0.5) beds per 10,000 population in the service area of the proposal.

   The bed need was calculated by the Tennessee Department of Health, Division for Policy, Planning and Assessment. The 2015 bed need for the applicant's proposed total service area is 122 beds. There are currently 105 licensed beds plus 34 approved but unimplemented beds in the service area for a total of 139 beds. The result is a bed surplus of seventeen (17) beds in the proposed service area.

   It appears that this criterion will not be met.

2. If the project is a bed addition, existing long term care hospital beds must have a minimum average occupancy of 85%.

   There are three long term care hospitals in the proposed service area. The applicant, Select Specialty Hospital–Memphis (39 beds), has experienced occupancy rates of 94.6% in 2009, 89.1% in 2010 and 94.6% in 2011. Methodist Extended Care (36 beds) operated at 89.5%, 86.6%, and 86.3% during the same time period. Baptist Memorial Restorative Care Hospital (30 beds) has operated at 85.2%, 73.2%, and 73.1% during this timeframe. Average areawide occupancy was 90.4% in 2009, declining to 83.7% in 32010, and increasing to 85.6% in 2011.

   It appears that this criterion has been met.

3. The population shall be the current year's population, projected two years forward.

   The Tennessee Department of Health, Division of Policy, Planning and Assessment utilized the applicant's projected total population of the total service area two years forward (2,433,814 residents in CY2015).

It appears that this criterion is met.

4. The primary service area cannot be smaller than the applicant's Community Service Area (CSA). If LTH beds are proposed within an existing hospital, CSAs served by the existing facility can be included along with consideration for populations in adjacent states when the applicant provides documentation (such as admission sources from the Joint Annual Report).

   The applicant states that it has conformed its West Tennessee service area to the boundaries of the West Tennessee CSA.

   It appears that this criterion is met.

5. Long-term care hospitals should have a minimum size of 20 beds.

   The applicant currently is licensed for 39 beds, has an additional 10 beds approved though the exemption for hospitals under 100 beds and is requesting 28 additional beds through this application.

   It appears that this criterion is met.

B. Economic Feasibility

1. The payer costs of a long-term hospital should demonstrate a substantial saving, or the services should provide additional benefit to the patient over the payer cost or over the provision of short-term general acute care alternatives, treating a similar patient mix of acuity.

   The applicant demonstrates that its gross average charge per patient day is significantly less than charges at service area short-term general acute care hospitals. Select had an average gross charge per patient day in 2011 of $4,111. Except for one short-term care hospital, area hospitals have average charges per day in the range of $5,781 to $9,387

   It appears that this criterion is met.

2. The payer costs should be such that the facility will be financially accessible to a wide range of payers as well as to adolescent and adult patients of all ages.

The applicant states that patients aged 18+ are enrolled in Medicare, Commercial, and Medicaid programs. The applicant also notes that it only contracts with one TennCare MCO in the service area, BlueCare. The applicant also stated that admissions are available on a negotiated basis with United Healthcare Community Plan and a contract request was declined by TennCare Select. The applicant also notes that it takes admissions on a negotiated basis from the Arkansas and Mississippi Medicaid programs.

It appears that this criterion has been met.

3. Provisions will be made so that a minimum of 5% of the patient population using long-term acute care beds will be charity or indigent care.

The applicant states that even though its Historical and Projected Data Charts do not reflect charity or indigent care, it does note that it has provided uncompensated care in excess of 5% in each of the three years 2009-2011. .

Since these uncompensated days of care are not directly related to charity or indigent care, it appears that this criterion has not been met.

C. Orderly Development

1. Services offered by the long term care hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional nursing (requiring approximately 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

The applicant states that Select Specialty Hospital-Memphis is located within a 24-hour hospital with a full array of acute care physician specialties available. The applicant states that it provides 12.87 hours per patient day of nursing and therapeutic services.

It appears that this criterion is met.

Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long-term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

Select Specialty Hospital-Memphis is an existing LTACH provider that is already providing these services.

It appears that this criterion is met.

Also, to avoid unnecessary duplication, the project should not include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term care hospitals.

The applicant states that Select Specialty Care-Memphis will never provide services not appropriate for long term acute care hospitals.

It appears that this criterion is met.

2. The applicant should provide assurance that the facility's patient mix will exhibit an annual average aggregate length of stay greater than 25 days as calculated by the Health Care Finance Administration (HCFA), and will seek licensure only as a hospital.

Select Specialty Hospital-Memphis has maintained an average length of stay in the range of 28.7 to 32.2 days over the last four years.

It appears that this criterion is met.

3. The applicant should provide assurance that the projected caseload will require no more than three (3) hours per day of rehabilitation.

The applicant's rehabilitation hours per patient day has ranged between 3.03 and 3.23 over the past two years.

It appears that this criterion is met.

4. Because of the very limited statewide need for long term hospital beds, and their high overall acuity of care, these beds should be allocated only to community service areas and be either inside or in close proximity to tertiary referral hospitals, to enhance physical accessibility to the largest concentration of services, patients, and medical specialists.

   The applicant states that it is located within the West Tennessee CSA and is within five miles of three tertiary hospitals.

   It appears that this criterion is met.

5. In order to insure that the beds and the facility will be used for the purpose certified, any certificate of need for a long term care hospital should he conditioned on the institution being certified by the Health Care Financing Administration as a long term care hospital, and qualifying as PPS-exempt under applicable federal guidelines. If such certification is received prior to the expiration date of the certificate of need, as provided in Tennessee Code Annotated (TCA), Section 68-11-108(c), the certificate of need shall expire, and become null and void.

   The applicant states it is presently certified as a long term acute hospital and qualified as PPS-exempt.

   It appears that this criterion is met.

SUMMARY:

The applicant, Select Specialty Hospital-Memphis, is currently a thirty-nine (39) bed long term acute care hospital (LTACH) located on the 12th floor of St. Francis Hospital at 5959 Park Avenue in Memphis (Shelby County). The applicant is requesting twenty-eight (28) additional LTAC beds to be placed on the 11th floor of St. Francis Hospital. Per TCA 68-11-1607(8)(g) "A hospital with fewer than one hundred (100) beds may increase its total number of licensed beds by ten (10) over any period of one (1) year without obtaining a certificate of need. The hospital shall provide written notice of the proposed increase in beds to the agency on forms provided by the agency, prior to the hospital's request for review to the board of licensing health care facilities". The applicant notified the

Agency of its intent to add ten (10) LTAC beds on October 5, 2012. The applicant expects to also place these 10 beds on the 11th floor resulting in a 38 bed floor. Taking the current 39 licensed beds, adding the additional 10 beds exempted from CON review plus the 28 beds being requested in this application, if approved, the result will be a 77 bed LTACH. The applicant has also stated that St. Francis Hospital will delicense the same number of acute care hospital beds on the 11th floor that Select will re-license as long term acute care.

Note to Agency members: All existing LTACHs (except one) in the service area are under 100 beds, so that all existing LTACHs (except one) are eligible to add 10 licensed beds without a CON if they so choose. (Exception: CN1210-052, Memphis Long Term Care Specialty Hospital has a condition that the addition of any beds requires a CON)

The 11th floor of St. Francis Hospital is currently an acute care nursing unit consisting of 38 private rooms. The floor contains 21,677 square feet. The applicant states that the 11th floor is older space that has not been updated for many years and requires remodeling and renovation. The renovation will consist of updating the wall, floor, and ceiling surfaces, cabinetry, and fixtures, and allowing for plumbing, HVAC, and electrical work. Select Specialty Hospital- Memphis will lease the additional space from St. Francis Hospital.

The applicant states the following reasons for why the project is needed:

- There are only three LTAC facilities in the service area operating at an average occupancy rate of 86.3%
- Select Specialty Hospital-Memphis is operating above 93% occupancy
- This project should not impact existing providers. The Baptist and Methodist LTAC facilities have high utilization. The 24-bed LTACH at the Regional Medical Center of Memphis (The MED), an approved but yet to be implemented project, expects to be fully occupied by The MED acute care patients.

Select Specialty Hospital-Memphis (SSH-M) was originally established through a CON issued to St. Francis Hospital, CN9406-032A, on September 28, 1994 for the establishment of a thirty (30) bed long-term acute care hospital. It appears that Select Specialty acquired the LTACH in 1998. SSH-M is wholly owned by Select Medical Corporation. According to its website Select Medical Corporation (SMC) operates long-term acute care hospitals, medical rehabilitation hospitals or physical therapy outpatient clinics in over 30 states. In addition to Select

Specialty Hospital-Memphis, Select Medical Corporation operates four other LTACHs in Tennessee: Select Specialty Hospital-Nashville (57 beds), Select Specialty Hospital-Knoxville (35 beds), Select Specialty Hospital-North Knoxville (33 beds), and Select Specialty Hospital-TriCities (33 beds).

Long-term acute care hospitals (LTACHs) provide extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that require hospital-level care for relatively extended periods. Typical conditions suitable for admission to LTACH include chronic respiratory disorders and other pulmonary conditions; cardiac, neurological, and renal conditions, infections and severe wounds. A facility must meet Medicare's conditions of participation for acute care hospitals and have an average inpatient length of stay greater than 25 days to qualify as an LTACH for Medicare payment. CMS established regulations to prevent general acute care hospitals from operating LTACHs, but a separate "hospital within a hospital" can qualify, which is the category in which the applicant facility falls.

There are other limitations by CMS regarding source of admissions that LTACHs must follow known as the "25% Rule". In the first supplemental response the applicant points out that this rule limits the percentage of admissions that can be referred from the Host hospitals, which for the applicant is St. Francis Hospital. The applicant states that through November 30, 2013 50% of its Medicare admissions may be referred from St. Francis. After December 1, 2013 that percentage reduces to 25%. The applicant states that historically approximately 20% of its admissions are referred from St. Francis so that Select is in compliance with the referral limitation rules of Medicare. The applicant also discusses being in compliance with referral limitations regarding Baptist and Methodist hospitals.

The applicant also points out in the first supplemental response that CMS (Centers for Medicare and Medicaid Services) established a three year moratorium that began on December 29, 2007 on the designation of new LTACHs or LTACH satellites or an increase of beds in an existing LTACH. On July 23, 2010 the moratorium was extended with an expiration date of December 29, 2012. It is unknown if the moratorium will be re-instituted at a future date but the applicant believes that providers should be ready to occupy needed beds after the moratorium expires. Legislation will need to be introduced and passed in 2013 to re-establish the moratorium. The applicant indicates there is currently an opportunity to add needed LTACH beds during this period.

The applicant states that the SSH-M's primary service area includes two counties in Arkansas (Crittenden and St. Francis), seven counties in Mississippi (Alcorn, DeSoto, Lafayette, Lee, Marshall, Panola, and Tate); and eight counties in Tennessee (Dyer, Fayette, Gibson, Lauderdale, Madison, McNairy, Shelby, and Tipton). The applicant reports that the primary service area counties account for over 85% of admissions and are distributed as displayed in the table below:

Patient Origin	% Admissions	Cumulative %
Shelby, TN	56.1%	56.4%
DeSoto, MS	7.4%	63.8%
Tipton, TN	2.4%	66.2%
Madison, TN	2.1%	68.3%
Fayette, TN	2.0%	70.3%
Marshall, MS	1.8%	72.1%
Dyer, TN	1.8%	73.9%
Tate, MS	1.4%	75.3%
Panola, MS	1.4%	76.7%
Alcorn, MS	1.2%	77.9%
Lee, MS	1.2%	79.1%
Lafayette, MS	1.1%	80.2%
Crittenden, AR	1.1%	81.3%
Gibson, TN	1.1%	82.4%
St. Francis, AR	0.9%	83.3%
Lauderdale, TN	0.9%	84.2%
McNairy, TN	0.9%	85.1%
Secondary Service Area	11.1%	96.2%
Tertiary Service Area	3.8%	100.0%

Source: CN112-062

According to population estimates by the Division of Health Statistics, Tennessee Department of Health (TDOH), the total population of the Tennessee portion of the service area is expected to increase by approximately 1.5% from 1,607,999 residents in CY 2013 to 1,632,644 residents in CY2015. The State of Tennessee population is expected in increase by approximately 1.8% from 6,414,297 in 2013 to 6,530,459 in 2015.

The following table displays demographic statistics for all the counties in the applicant's primary service area based on US Census data and for the Tennessee counties only, TennCare statistics.

Geography	2010 Pop.	2012 Pop.	10 - '12 % Change	Age 65+ % Total	Median HH Income	% Below Poverty Level	TNCare Enrollees	TNCare Enrollees As % of Total Pop.
Tennessee	**6,346,113**	**6,456,113**	**1.7%**	**13.7%**	**43,989**	**16.9%**	**1,205,480**	**18.7%**
Dyer	38,337	38,255	-0.2%	14.8%	38,409	19.2%	9,392	24.6%
Fayette	38,413	38,659	0.6%	15.5%	57,437	11.7%	5,645	14.6%
Gibson	49,683	49,626	-0.1%	16.6%	37,577	17.9%	11,075	22.3%
Lauderdale	27,815	27,718	-0.3%	12.7%	34,078	25.3%	7,216	26.0%
Madison	98,294	98,656	0.4%	13.5%	40,667	19.2%	21,111	21.4%
McNairy	26,075	26,180	0.4%	17.7%	34,953	22.5%	6,950	26.5%
Shelby	927,640	940,764	1.4%	10.4%	46,102	20.1%	230,486	24.5%
Tipton	61,081	61,705	1.0%	11.4%	50,869	15.3%	11,675	18.9%
Arkansas	**2,915,919**	**2,949,131**	**1.1%**	**14.6%**	**40,149**	**18.4%**		
Crittenden	50,902	50,021	-1.7%	11.1%	35,624	27.9%		
St. Francis	28,258	27,858	-1.4%	12.6%	26,260	29.7%		
Mississippi	**2,967,299**	**2,984,926**	**0.6%**	**13.0%**	**38,718**	**21.6%**		
Alcorn	37,057	37,164	0.3%	16.2%	32,221	20.2%		
DeSoto	161,256	166,234	3.1%	10.5%	59,734	9.5%		
Lafayette	47,357	49,495	4.5%	10.6%	41,166	23.8%		
Lee	82,910	85,042	2.6%	13.1%	41,150	18.2%		
Marshall	37,143	36,612	-1.4%	13.3%	33,279	24.2%		
Panola	34,701	34,473	-0.7%	13.0%	34,592	28.1%		
Tate	28,886	28,490	-1.4%	13.1%	41,839	18.1%		

Source: US Census Bureau, TennCare

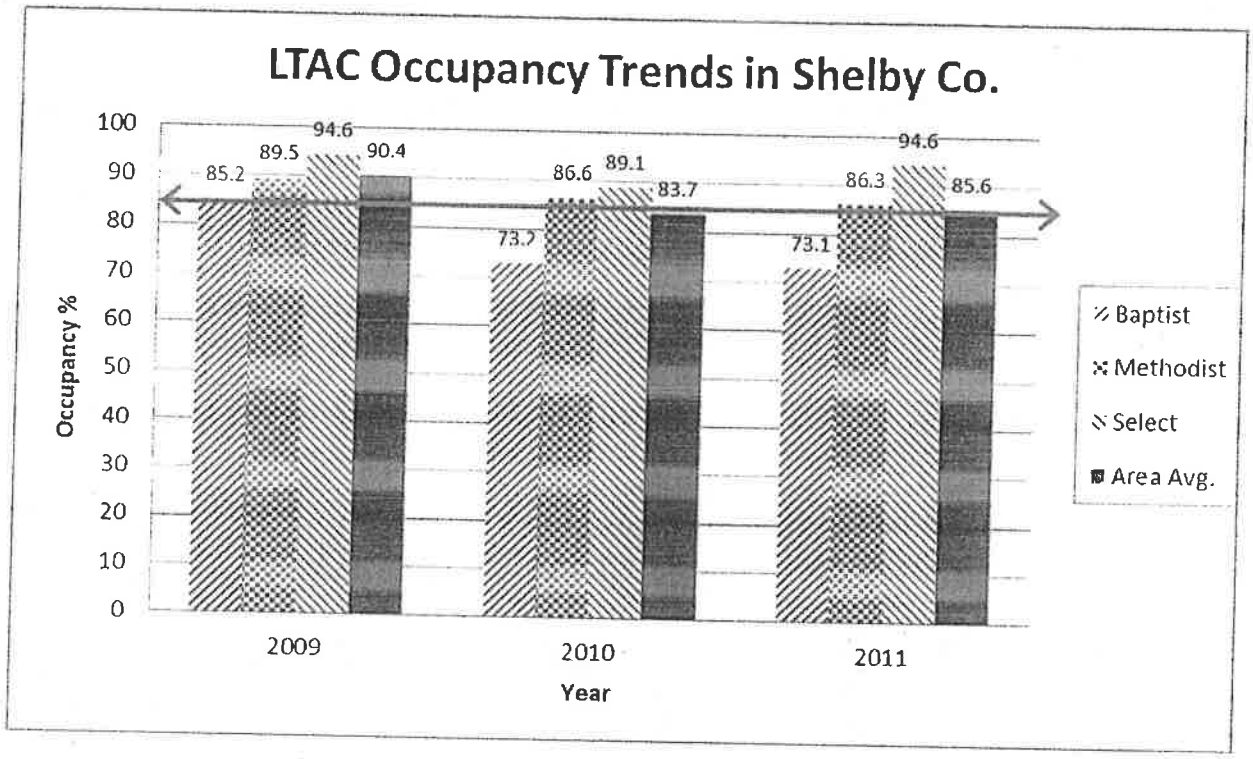
The chart above indicates that all the Tennessee counties in the service area are growing (or declining) at rates less than the Tennessee average, four of the eight Tennessee counties have a higher proportion of Age 65+ population than Tennessee overall, Five of the eight counties have a median household income below the Tennessee median, and six counties have a higher percentage of population below the poverty level than Tennessee overall. The population of the two counties in Arkansas is expected to decline, have a smaller percentage of population Age 65+ than Arkansas overall, have median income below the State median and a greater % of population below the poverty level. Three of the seven Mississippi counties in the service area are expected to have populations that increase more than the state of Mississippi overall. Five of the seven counties have an Age 65+ population equal to or greater than the State

percentage. Three of the counties have a population percentage above the poverty level for the state overall. Seven of the eight Tennessee primary service area counties have a higher percentage of TennCare recipients than the state overall.

The bed need formula from the project specific criteria for long term care hospitals in Tennessee's Health Guidelines for Growth, 2000 Edition, is based upon a ratio of 0.5 beds per 10,000 population *(2 years forward from the current population)* in the service area of the proposal. Using the declared service area population for CY2015 the applicant estimated a need for 122 total LTAC beds. This amount less the number of existing licensed and approved but yet to be implemented LTAC beds (139 *total beds),* accounts for the applicant's estimate that there will be a projected surplus of 17 LTAC beds in the proposed service area. The TDOH project summary reported the same bed need results.

There are three long term care hospitals operating in the proposed service area. The applicant, SSH-M (39 beds plus 10 beds approved but unimplemented per the "Hospital Under 100 bed exemption"), Methodist Extended Care (36 beds), Baptist Memorial Restorative Care Hospital (30 beds). The MED has an outstanding CON for the relocation of approved but unimplemented 24 bed LTACH to its campus (CN1210-052A), resulting in 105 licensed LTACH beds and 34 approved but unimplemented LTACH beds for a total of 139 LTACH beds in the service area. The applicant also notes that there are LTACHs in Nashville, Arkansas, and Mississippi but points out that only three of the twenty-one west Tennessee counties in the service area have a shorter driving time to Nashville than Memphis and all but two of the twenty-one Arkansas and Mississippi counties in the declared project service area are closer to Memphis than to LTACHs in their home states.

The occupancy trends for the existing LTACHs with comparison to the LTACH's criteria and standards' occupancy guideline of 85% are displayed in the following graph.



As the chart above displays, two of the three existing LTACHs have attained the occupancy standard of 85% and the overall annual average occupancy for the three facilities was 85.6% in 2011.

The first year after project completion (2014), the applicant expects the 77 bed LTACH to attain an occupancy rate of 68.8% and increase to 76.6% in 2015. By the fourth year of operation (2017) the applicant expects to attain an occupancy rate of 93.8%. The applicant expects that outreach marketing in Mississippi, Arkansas, and rural west Tennessee will support the projected increase in admissions.

According to the Projected Data Chart for the proposed twenty-eight (28) beds, the applicant expects gross operating revenue of $18,561,633.00 on 4,088 patient days in Year One of the project increasing by approximately 57% to $29,145,658 ($4,670 per patient day) in Year Two. The proposed LTAC bed addition expects to realize favorable operating margins before capital expenditures at an initial level of approximately 4.47% of total net operating revenue in the first year of operations.

For the total 77 bed facility after project completion, the applicant expects gross operating revenue of $87,875,704 on 19,435 patient days in Year 1 and expects to increase 14.6% to $100,672,847 on 21,535 patient days in the second year of operation. The LTACH after project completion expects to realize favorable operating margins before capital expenditures at an initial level of approximately 4.7% of total net operating revenue in the first year of operations.

Historically SSH-M has had a payor mix that included 80% Medicare and 3.3% TennCare/Medicaid. The applicant expects this payor mix to remain the same after project completion.

One of the criteria in the LTACH criteria and standards in the State Health Plan indicates that payer costs in LTACHs should demonstrate a substantial savings compared to the payor costs of a short term general acute care hospital. Utilizing Joint Annual Report data the average gross charge per patient day for the LTACHs in Shelby County ranged from $3,318 to $5,365 averaging $4,228 per day. The average gross charge per patient day for short-term acute care hospitals in Shelby County ranged from $2,626 to $9,387 averaging $7,279 per day.

According to the Historical Data Chart, Select Specialty Hospital-Memphis has been profitable for each of the last three years reporting favorable net operating income (NOI) after capital expenditures of $3,191,077.00 in 2009; $1,882,659.00 in 2010; and $1,089,237.00 in 2011. Average annual NOI was favorable at approximately 5.3% of annual net operating revenue for the year 2011.

The total estimated project cost is $6,898,905. Over 47% of the project cost is facility lease cost ($3,251,550) and another 30% of the cost is construction cost ($2,059,315). Moveable equipment accounts for another 18% of the total project cost ($1,059,315).

The applicant will be renovating the 21,677 square foot 11th floor of St. Francis Hospital for the proposed project. The facility renovation is estimated at $2,059,315 or approximately $95.00 per square foot. The projected cost per square foot is less than the 1st quartile cost of $125.84 for approved hospital renovation projects between 2009 and 2011.

The applicant has provided a letter dated December 20, 2012 from Brasfield and Gorrie, General Contractors that indicates the proposed renovation will meet all

applicable federal, state, and local requirements including the current AIA Guidelines for Design and Construction of Health Care Facilities.

Funding support for the project is available from the corporate parent of SSH-M, Select Medical Corporation, per a letter dated December 14, 2012 from the Executive Vice President & CFO attesting to the availability of $3,647,000.00 from cash reserves and operating income to fund the proposed project.

Select Medical Corporation (Memphis) reported total assets of $17,665,966.85, including $2,601,862.66 in current assets, for the period ending October 31, 2012. Total current liabilities were ($412,519.24). The current liabilities include $1,825,872.01 due from a third party payor. When this amount is excluded from current liabilities the current ratio is lowered to 1.84 to 1. Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

The applicant also included financial statements for Select Medical Corporation. Review of the balance sheet revealed current assets of $483,410,000.00 and current liabilities of $386,062,000.00 for the 12-month fiscal year (FY) period ending December 31, 2011. Review of the Consolidated Statements of Operations revealed net total revenue of $2,804,507,000.00 and net income of $112,762,000.00 after depreciation and income tax expense during the period. Basic and diluted income per common share rose from .61 cents in 2009 to .71 cents in 2011.

The SSH-M's current staffing is 128.2 FTEs and is expected to increase by 55.8 FTEs by the second year of operation. The largest increases are RNs, 39.6 FTEs increasing by 23.3 FTEs to 62.9 FTEs and CNAs, 30.6 FTEs increasing by 15.7 FTEs to 46.3 FTEs

The applicant has submitted the required corporate documentation, real estate option to lease and requisite demographic information for the applicant's proposed service area. HSDA staff has reviewed these documents. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.

Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT

There are no other Letters of Intent, denied or pending applications for this applicant.

Outstanding Certificates of Need

Select Specialty Hospital-Nashville, CN1210-053A, has an outstanding Certificate of Need which will expire on April 1, 2016. It was approved at the February 27, 2013 Agency meeting for the addition of thirteen (13) long term acute care (LTAC) beds to its current forty-seven (47) bed LTAC hospital. The applicant is also in the process of adding ten (10) beds through the exemption for hospitals with less than 100 beds. If approved, the final bed count for the facility will be seventy (70) LTAC beds. The estimated cost of the project is **$3, 4853,811.00.** *Project Status: This project was recently approved.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, pending or denied applications for other health care organizations in the service area proposing this type of service.

Memphis Long Term Care Specialty Hospital, CN1210-052A, has an outstanding Certificate of Need which will expire on February 1, 2016. It was approved at the December 12, 2012 Agency meeting for the relocation of a previously approved but unimplemented CON (CN0908-046AE) for a twenty four (24) bed long-term care acute care hospital (LTACH) from the intersection of Kirby Parkway and Kirby Gate Boulevard, Memphis (Shelby County) to an existing building on the campus of the Regional Medical Center at Memphis (The MED), 877 Jefferson Avenue, Memphis (Shelby County). The LTACH will be placed on the 4th floor of the Turner Tower and will be a separately licensed hospital from The MED. The estimated cost of the project is **$8,208,743.00**. *Project Status: This project was recently approved.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

MAF
05/07/2013

LETTER OF INTENT

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

2012 DEC 10 AM 9:54

The Publication of Intent is to be published in the Memphis Commercial Appeal, which is a newspaper of general circulation in Shelby County, Tennessee, on or before December 10, 2012, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Select Specialty Hospital-Memphis (a long term acute care hospital), owned and managed by Select Specialty Hospital-Memphis, Inc. (a corporation), intends to file an application for a Certificate of Need to add twenty-eight (28) long term acute care beds to its facility, located in leased space at St. Francis Hospital, 5959 Park Avenue, Memphis, TN 38119. The project cost for CON purposes is estimated at $6,900,000. The project contains no major medical equipment and does not add or discontinue any new health service.

Select Specialty Hospital is currently licensed by the Board for Licensing Healthcare Facilities (TN Department of Public Health) for thirty-nine (39) long term acute care beds. Select Specialty has received State approval for licensure of ten (10) additional long term acute care beds without CON review, under a statutory exemption available to hospitals of fewer than 100 beds. Upon its implementation, Select will be licensed for forty-nine (49) long term acute care beds, so that the twenty-eight (28) bed expansion proposed in this Certificate of Need application would increase the Select license to seventy-seven (77) long term acute care beds. St. Francis Hospital, which is leasing these beds to Select, will reduce its current 519-bed general hospital license by 10 beds to reflect the approved 10-bed expansion of Select through the CON exemption process, and will reduce its license by 28 more beds if this CON application is approved. The net effect of these changes will be that the project will not change the service area's total licensed complement of general acute care plus long term acute care hospital beds. The anticipated date of filing the application is on or before December 14, 2012. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 12-9-12 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

ORIGINAL APPLICATION

SELECT SPECIALTY HOSPITAL MEMPHIS

CERTIFICATE OF NEED APPLICATION TO ADD 28 LONG TERM ACUTE CARE BEDS

Submitted December 2012

1. ***Name of Facility, Agency, or Institution***

Select Specialty Hospital--Memphis
Name

5959 Park Avenue
Street or Route

Shelby
County

Memphis
City

TN
State

38119
Zip Code

2. ***Contact Person Available for Responses to Questions***

John Wellborn
Name

Title

Development Support Group
Company Name

jwdsg@comcast.net
Email address

4219 Hillsboro Road, Suite 203
Street or Route

Nashville
City

TN
State

37215
Zip Code

CON Consultant
Association with Owner

615-665-2022
Phone Number

615-665-2042
Fax Number

3. ***Owner of the Facility, Agency or Institution***

Select Specialty Hospital--Memphis, Inc.
Name

901-761-3013
Phone Number

5959 Park Avenue
Street or Route

Shelby
County

Memphis
City

TN
State

38119
Zip Code

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	
D. Corporation (For Profit)	✓	I. Other (Specify)_____	
E. Corporation (Not-for-Profit)			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity (If Applicable)***

NA
Name

Street or Route

County

City

State

Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A. Ownership
B. Option to Purchase
C. Lease of 5 Years
D. Option to Lease
E. Other (Specify) _____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A. Hospital (Specify)
B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty
C. ASTC, Single Specialty
D. Home Health Agency
E. Hospice
F. Mental Health Hospital
G. Mental Health Residential Treatment Facility
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)
I. Nursing Home
J. Outpatient Diagnostic Center
K. Recuperation Center
L. Rehabilitation Facility
M. Residential Hospice
N. Non-Residential Methadone Facility
O. Birthing Center
P. Other Outpatient Facility (Specify)_____
Q. Other (Specify) _____

8. **Purpose of Review *(Check) as appropriate--more than one response may apply)***

A. New Institution
B. Replacement/Existing Facility
C. Modification/Existing Facility
D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)_____
E. Discontinuance of OB Services
F. Acquisition of Equipment
G. Change in Bed Complement *[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]* ✓
H. Change of Location
I. Other (Specify)_____

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	Current Beds *CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital	39	10	39	28	77
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	39	10	39	28	77

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** 44-2014
Certification Type long term care hospital

11. **Medicaid Provider Number** 044-2014
Certification Type long term care hospital

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?** p. 4

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants?** p. 4 **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

This is an existing facility, already certified for Medicare and Medicaid. No change in certification is anticipated.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

Approximately 75%-80% of an LTACH's admissions tend to be elderly, and include patients who are also Medicaid-eligible. Select Specialty Hospital-Memphis is currently contracted with the BlueCare TennCare MCO--which has West Tennessee's largest enrollment. Select is also contracted with TennCare Select.

TennCare and Medicaid patients from Mississippi and Arkansas are accepted on an individually negotiated basis.

The applicant's Medicaid days of care the past two years have averaged between 3% and 4% of its total days of care.

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
BlueCare (largest plan in W. TN)	Contracted
United Healthcare Community Plan (formerly AmeriChoice) (2nd largest plan)	Not contracted; admissions available on a negotiated basis
TennCareSelect (very small enrollment)	Contracted

SECTION B: PROJECT DESCRIPTION

B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

Proposed Services and Equipment

• The applicant is a Long Term Acute Care Hospital ("LTACH"). That is a special category of small Medicare-certified hospitals. They admit primarily (but not only) vulnerable Medicare patients who need prolonged inpatient acute care (25+ days), after discharge from a short acute care stay at a general hospital.

• The 39-bed Select Specialty Hospital is the largest LTACH in Memphis. All 39 of its beds are in leased space on the 12th floor of St. Francis Hospital in East Memphis. Recently, Select Specialty received approval to add 10 beds (under an exemption from CON). St. Francis has agreed to lease its vacant 38-bed 11th floor to Select, for that expansion. Ten more beds can now be licensed to Select immediately. However, the entire floor needs updating through renovation and remodeling. This application is to license the remaining 28 beds on that 11th floor, which if approved will allow Select to renovate the entire 38-bed floor before moving many new patients onto the floor.

• St. Francis has agreed to delicense on this floor the same number of short term hospital beds that Select will re-license as long term acute care. So the project will not increase the area's total of long term plus short term hospital beds, or construct new bed space.

Ownership Structure

• Select Specialty Hospital--Memphis, Inc., the applicant, is wholly owned by Select Medical Corporation, a national LTACH company with five Tennessee facilities. Attachment A.4 contains information on the five Tennessee facilities it owns in Memphis, Nashville, Knoxville (2), and Tri-Cities.

• The facility is self-managed. It has no management contract with its parent company. The parent company provides certain support services to its hospitals, for which the hospitals are billed as "management fees", but at Select that is a practical business term and does not indicate a legal relationship other than normal parent-subsidiary ownership.

Service Area

• LTACH's typically have extensive service areas because they are located in cities with tertiary care centers that admit patients from a wide geographic service area, and then discharge some of those patients to LTACH's to continue prolonged acute care.

• During the past three years, Select Specialty Hospital has had a primary service area (85% of admissions) consisting of 17 contiguous counties in West Tennessee, Mississippi, and Arkansas (all closer to Memphis than to other cities with LTACH's). It

has had a primary and secondary service area (96.7% of admissions) consisting of 43 contiguous counties in those States (all but a few of which are closer to Memphis than to alternative LTACH's). It admitted patients from 78 counties in eight States.

Need

• There are only three LTACH's in the entire primary and secondary service area, and all of them are in Memphis. In the most recent reporting year, their Joint Annual Reports showed an average occupancy of 86.3%. Select is the largest and busiest of the Memphis LTACH's, and its occupancy over the past forty-eight months has averaged higher 93%. The smallest and least occupied is at 75.5% occupancy and will be at 85% occupancy with an additional census of only 28 patients.

• At such high occupancies, additional LTACH beds are appropriate. Although the LTACH bed need formula in the Guidelines for Growth does not indicate "need" for more beds, the same Guidelines allow the HSDA to consider bed additions once areawide LTACH occupancy reaches 85%--which has been exceeded in Memphis for at least three years.

• It is also relevant that the CON statute allows small hospitals (<100 beds) to add 10 beds every year without CON approval. Without CON, the 38 total beds Select can lease on this floor could be added in stages each year, until all 38 are licensed in early CY2016—only three years from now. But staging bed licensure will require staged renovation around patients being hospitalized on that floor. The alternative requested in this application is to let Select lease and license the remaining 28 beds from St. Francis without delay, making it feasible to invest in renovating the entire floor at the same time.

Existing Resources

• The LTACH's in the service area last reported a combined average occupancy of 86.3%. They are Select Specialty Hospital-Memphis (39 beds; 94.6% occupancy); Methodist Extended Care Hospital (36 beds; 86.3% occupancy); and Baptist Memorial Restorative Care Hospital (30 beds; 75.5% occupancy).

Project Cost, Funding, Financial Feasibility

• The actual capital cost of the project is estimated at $3,646,842. The CON cost, which includes the estimated value of the space being leased from St. Francis, is $6,898,842. The capital cost can be provided from the hospital's current assets. It could also be provided by a cash transfer from the parent company. Select Specialty Hospital--Memphis now operates with a positive margin and will continue to do so as it expands. The project is a small expenditure for an acute care facility and it will not raise the cost of care to Medicare or other payors. St. Francis Hospital itself would have to spend a similar amount of money to update and use the floor in the future, if Select were not leasing it.

Staffing

• The hospital projects that by Year Two of the expanded 77-bed complement, 55.8 additional employees will be required.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.)* INCLUDING SQUARE FOOTAGE, MAJOR OPERATIONAL AREAS, ROOM CONFIGURATION, ETC.

Table Two: Summary of Construction and Changes in Size	
	Total Square Feet
Facility Before Project	21,677 SF (12th floor of host hospital)
Facility After Project	43,354 SF (11th & 12th floors of host)
Area of New Construction	none
Area of Buildout or Renovation	21,677

Table Three: Construction Costs of This Project			
	Renovated Constuction	**New Construction**	**Total Project**
Square Feet	21,677 SF	none	21,677 SF
Construction Cost	$2,059,315	none	$2,059,315
Constr. Cost PSF	$95	none	$95

Select Specialty Hospital--Memphis ("Select Specialty") is licensed to operate a 39-bed long term acute care hospital ("LTACH") in Memphis. It is located at St. Francis Hospital, from whom Select Specialty leases the entire 39-bed 12th floor. Among Memphis's three operational LTACH's, Select Specialty is by far the most highly utilized, both in terms of annual patients served, and also in terms of occupancy (93% average over the past 48 months).

In December 2012, having higher than 90% occupancy during the past four-year period, Select Specialty requested and received HSDA approval to add 10 beds to its licensed complement without CON review, under a statutory exemption available to hospitals of fewer than 100 beds. However, no more beds are available on the 12th floor. So St. Francis has agreed to expand Select Specialty's leased space to include the

hospital's vacant 11th floor immediately below. The 11th floor is an acute care nursing unit consisting of 38 private rooms. It is older space that has not been updated for many years. It will require remodeling and renovation, but its floor plan need not be changed significantly. Because future bed expansions are anticipated, Select Specialty hopes to update the entire 38-bed 11th floor at one time, prior to occupying even the 10 recently approved beds, so that construction will not be required on an operational patient floor.

Select Specialty estimates that the 11th floor can be brought up to standards at an overall renovation cost of no more than $95 PSF, which will update the wall, floor, and ceiling surfaces, cabinetry, and fixtures, and allow for plumbing, HVAC, and electrical work. It will also cover heavier renovation if that is found to be needed. Tables One and Two below show the current and proposed floor space of the facility, and the projected cost of the renovation required to modernize it into LTACH space meeting Select Specialty's standards.

(Note: CMS is the Federal Center for Medicare/Medicaid Services; replacement for HCFA) In 2008, CMS placed a moratorium on Medicare certification of additional LTACH beds nationwide. This was extended once and is now scheduled to expire December 31, 2012. The Medicare moratorium may or may not be extended; but the applicant sees that as irrelevant to a CON decision on this application, because its future is unpredictable, and because Tennessee can license the beds it chooses regardless of when they might obtain Medicare certification. Providers should be ready to occupy needed beds as soon as the moratorium is lifted, and not have to wait four more months after the moratorium's expiration, to complete a CON process. As in other LTACH CON approvals since 2008, this efficiency can be accomplished simply by making operation of approved beds conditional on subsequent CMS certification.

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART.

UTILIZING THE ATTACHED CHART, APPLICANTS WITH HOSPITAL PROJECTS SHOULD COMPLETE PARTS A-E BY IDENTIFYING, AS APPLICABLE, NURSING UNITS, ANCILLARY AREAS, AND SUPPORT AREAS AFFECTED BY THIS PROJECT. PROVIDE THE LOCATION OF THE

UNIT/SERVICE WITHIN THE EXISTING FACILITY ALONG WITH CURRENT SQUARE FOOTAGE, WHERE, IF ANY, THE UNIT/SERVICE WILL RELOCATE TEMPORARILY DURING CONSTRUCTION AND RENOVATION, AND THEN THE LOCATION OF THE UNIT/SERVICE WITH PROPOSED SQUARE FOOTAGE. THE TOTAL COST PER SQUARE FOOT SHOULD PROVIDE A BREAKOUT BETWEEN NEW CONSTRUCTION AND RENOVATION COST PER SQUARE FOOT. OTHER FACILITY PROJECTS NEED ONLY COMPLETE PARTS B-E.

See Attachment B.II.A.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

This project is more economical than most. By comparison, the estimated $2,059,315 remodeling/renovation cost for the project is projected to be only $95 PSF. The 2009-2011 acute care construction projects approved by the HSDA had the costs per SF shown in Table Three below. This project's $95 PSF cost is below even 1st quartile averages for renovation ($125 PSF).

Table Four: Hospital Construction Cost PSF
Years: 2009 – 2011

	Renovated Construction	New Construction	Total Construction
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$125.84/sq ft	$324.00/sq ft	$301.74/sq ft

Source: CON approved applications for years 2009 through 2011

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

At the time of this application in December 2012, Select Specialty Hospital holds a 39-bed license for long term acute care hospital beds, and also holds HSDA approval to add 10 more of the same--which will give Select Specialty a 49-bed LTACH license when implemented in CY2013. The 10 new beds will be licensed to Select pursuant to a lease of 10 more private rooms from St. Francis Hospital--beds that are currently general, short term (not long term) acute care beds on the 11th floor. St. Francis will drop those 10 beds from its general acute care license, at the time Select takes control of the space and relicenses them as Select's own long term acute care beds. That is expected to happen in CY2013. Its timing will depend on this CON decision. Select hopes to be able to renovate the entire floor prior to using it for numerous new patients.

The same type of re-licensure process is proposed in this application. Select Specialty is requesting CON approval to license the remaining 28 long term acute care beds on the 11th floor, which would increase its LTACH license to 77 beds--39 on the 12th floor and 38 on the 11th floor. Again, this would be accomplished by conversion of short term general acute care beds now licensed to St. Francis. Table Five below presents these changes visually. All Select beds are, and will be, private patient rooms. There are no double rooms in this facility or this project.

Table Five: Proposed Changes in Licensed Hospital Beds
Select Specialty Hospital and St. Francis Hospital
Memphis

Provider / Bed Licensure	Approved Bed Assignment	Proposed Bed Assignment
Select Specialty Hospital / Long Term Acute Care	39 + 10 u.c. = 49	49 + 28 = 77
Ft. Francis Hospital / General Acute Care	519 - 10 u.c. = 509	509 - 28 = 481
Select and St. Francis Hospitals Combined	acute care beds, general & long term = 558	acute care beds, general & long term = 558

Note: "u.c." or "under construction", means here that Select Specialty is preparing to add 10 approved long term acute care beds in 11th-floor patient rooms it will lease from St. Francis (which St. Francis will then remove from the St. Francis acute care license).

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION):

1. **ADULT PSYCHIATRIC SERVICES**
2. **ALCOHOL AND DRUG TREATMENT ADOLESCENTS >28 DAYS**
3. **BIRTHING CENTER**
4. **BURN UNITS**
5. **CARDIAC CATHETERIZATION SERVICES**
6. **CHILD AND ADOLESCENT PSYCHIATRIC SERVICES**
7. **EXTRACORPOREAL LITHOTRIPSY**
8. **HOME HEALTH SERVICES**
9. **HOSPICE SERVICES**
10. **RESIDENTIAL HOSPICE**
11. **ICF/MR SERVICES**
12. **LONG TERM CARE SERVICES**
13. **MAGNETIC RESONANCE IMAGING (MRI)**
14. **MENTAL HEALTH RESIDENTIAL TREATMENT**
15. **NEONATAL INTENSIVE CARE UNIT**
16. **NON-RESIDENTIAL METHADONE TREATMENT CENTERS**
17. **OPEN HEART SURGERY**
18. **POSITIVE EMISSION TOMOGRAPHY**
19. **RADIATION THERAPY/LINEAR ACCELERATOR**
20. **REHABILITATION SERVICES**
21. **SWING BEDS**

This is a small but necessary project. It will serve patients needing prolonged acute care hospital stays of more than three weeks, following their discharge from short term acute care hospitals. It will improve resources within a 43-county region around Memphis, meeting elderly, vulnerable patients' needs in the most cost-effective and optimal way currently available.

The applicant, Select Specialty Hospital, is a 39-bed Long Term Acute Care Hospital ("LTACH" in this application). A preceding section of this application describes its East Memphis location on the 12th floor of St. Francis Hospital, a mile south of the Interstate 240 loop around Memphis. Select is the largest LTACH in Memphis and in 43 counties of the three States it serves.

There are only three LTACH facilities in the entire primary and secondary service area, and all of them are in Memphis. In the most recent reporting year, their Joint Annual Reports showed an average occupancy of 86.3%.

Select is the largest and busiest of the Memphis LTACH's, with higher than 93% average occupancy over the past forty-eight months. Methodist Extended Care Hospital (36 beds; 86.3% occupancy in CY2011); and Baptist Memorial Restorative Care Hospital (30 beds; 75.5% occupancy in CY2011) are the other two LTACH's in the service area. It is worth noting that even the smallest of these facilities is at 75.5% occupancy, and will be at 85% occupancy with an additional census of only 2.8 patients.

In December 2012, having averaged higher than 90% occupancy over the past four-year period, Select Specialty requested and received HSDA approval to add 10 beds to its licensed complement without CON review, under a statutory exemption available to hospitals of fewer than 100 beds. Select and its host hospital, St. Francis, are now finalizing a lease to allow that to proceed by a conversion of beds from St. Francis' licensure to Select's licensure.

Because the CON statute allows small hospitals (<100 beds) to add 10 beds every year without CON approval, it was Select Specialty's original intention to add 10 beds on that floor in stages, through early 2016, reaching the floor's full 38-bed capacity, and bringing Select's total license to 77 LTACH beds.

But it has become apparent that the entire floor needs remodeling and updating of all its patient care spaces; and it would obviously be better for patient care if that work could be completed in a single project, before more than 10 patients are brought onto that floor. This application seeks HSDA approval for going ahead in CY2013 with leasing, licensing, and remodeling all 38 bed spaces on that floor, eliminating the need for phased construction over the next 36 months in active patient care areas. If this approval is granted, it will be financially feasible for Select to invest in taking control of the whole floor without a staged-construction project to manage for thirty-six months.

Need for the beds at Select is overwhelming. Select's occupancy consistently exceeds 90%; in both CY2011 and CY2012, Select occupancy has been approximately 93%. The hospital continuously defers or turns away admissions for lack of bed space. This has gone on for years. It seems appropriate not to delay any longer in meeting community requests for this type of care, at this location.

LTACH Bed Need Guidelines

As addressed in this application's section on the Guidelines for Growth, the very old LTACH bed need formula in the Guidelines for Growth does not indicate "need" for more LTACH beds in this service area. But neither does it indicate a significant surplus of LTACH beds. And significantly, the same Guidelines state that the HSDA may approve bed additions once areawide LTACH occupancy reaches 85%--and that has been exceeded in Memphis for at least three years. The applicant urges the HSDA Board to thoughtfully weigh this real-world high rate of demand, and the well-documented aging of many service area counties, against the abstract "need" formula in the Guidelines.

Impact on Other LTACH's

This project will not impact the MED's newly approved 24-bed LTACH (a relocation). Nor will the MED's opening of those beds reduce other LTACH's high occupancies. MED representatives demonstrated in their CON application process that the MED has more qualified LTACH patients on extended acute stays in the MED than the 24 new beds can hold. So it appears that the MED beds will be fully occupied by MED patients who are not now asking for admission to Select or to other LTACH's in Memphis.

The Baptist and Methodist LTACH facilities are not likely to be harmed by the addition of beds at Select. They have high utilization that is not going to switch to Select in any significant way; Select anticipates filling its new beds through new marketing efforts at rural hospitals that are not discharging all their qualified patients to Memphis LTACH's at this time. Moreover, the Select bed addition will occur in stages by CY2016, if not allowed to open in CY2014 pursuant to a CON; so denial of this application would not provide competitive benefits of any duration to any other area LTACH.

B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

Not applicable.

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF $1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

1. For fixed site major medical equipment (not replacing existing equipment):

- **a. Describe the new equipment, including:**
  1. **Total Cost (As defined by Agency Rule);**
  2. **Expected Useful Life;**
  3. **List of clinical applications to be provided; and**
  4. **Documentation of FDA approval.**
- **b. Provide current and proposed schedule of operations.**

2. For mobile major medical equipment:

- **a. List all sites that will be served;**
- **b. Provide current and/or proposed schedule of operations;**
- **c. Provide the lease or contract cost;**
- **d. Provide the fair market value of the equipment; and**
- **e. List the owner for the equipment.**

3. Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not applicable. The project contains no major medical equipment.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:

1. **SIZE OF SITE (IN ACRES);**
2. **LOCATION OF STRUCTURE ON THE SITE;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

Select Specialty Hospital is on the twelfth floor of its host hospital, St. Francis Hospital. Select's address is 5959 Park Avenue, Memphis, Tennessee 38119. This is in East Memphis, approximately one mile south of the Poplar Avenue exit from Interstate 240 Loop circling that side of Memphis. The campus is well known to residents of Shelby County. It is served by a municipal bus line. However, almost all patients use private transportation to come to Select Specialty Hospital, because they are acute care patients for whom public transportation is not appropriate if alternatives are available. The applicant has no way of knowing what means of transport is used by visiting families.

This facility has a regional service area, as one would expect of LTACH's in cities with large tertiary healthcare systems. It has forty-three counties in its full (primary and secondary) service area. Table Six on the following page provides distances and drive times between Select Specialty and the largest community (or county seat) in the 17 Tennessee primary service area counties (those providing 85% of Select Specialty's admissions). Memphis is the hub of a complex network of interstate and Federal highways that provide good access to Memphis providers for residents of Shelby County and the vast rural areas surrounding it. Table Seven on the same page provides distances and drive times between this project and other LTACH's in the primary service area.

Table Six: Mileage and Drive Times Between Project and Major Communities in the 17-County Primary Service Area			
Community	**County and State**	**Distance in Miles**	**Drive Time in Minutes**
1. Marion	Crittenden, AR	29.8	32"
2. Forrest City	Saint Francis, AR	65.2	64"
3. Corinth	Alcorn, MS	82.0	87"
4. Senatobia	DeSoto, MS	22.2	28"
5. Oxford	Lafayette, MS	70.6	83"
6. Tupelo	Lee, MS	101.0	99"
7. Holly Springs	Marshall, MS	40.1	46"
8. Batesville	Panola, MS	67.1	65"
9. Senatobia	Tate, MS	44.,8	46"
10. Dyersburg	Dyer, TN	77.5	100"
11. Somerville	Fayette, TN	42.2	44"
12. Trenton	Gibson, TN	89.7	102"
13. Ripley	Lauderdale, TN	55.5	78"
14. Jackson	Madison, TN	77.8	77"
15. Selmer	McNairy, TN	83.7	102"
16. Memphis	Shelby, TN	--	--
17. Covington	Tipton, TN	40.6	59"

Source: Google Maps, Dec. 2012

Table Seven: Mileage and Drive Times Between Project and the Three Other Approved Long Term Acute Care Hospitals in the 17-County Primary Service Area			
Facility and Address	**County and State**	**Distance in Miles**	**Drive Time in Minutes**
Select Specialty Hospital 5959 Park Avenue, Memphis, TN 38119	Shelby, TN	na	na
Baptist Memorial Restorative Care Hospital 2100 Exeter Road, Memphis, TN 38138*	Shelby, TN	3.1	5"
Methodist Extended Care Hospital 225 South Claybrook, Memphis, TN 38104	Shelby, TN	16.2	19"
Memphis Long Term Care Specialty Hospital 877 Jefferson Ave., Memphis, TN 38103	Shelby, TN	11.0	22"

Source: Google Maps, Dec. 2012

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

C(I) NEED

C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.

A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.

B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria: Long Term Acute Care Hospital (LTACH) Beds

A. Need

1. The Need for long term care hospital (LTH) beds shall be determined by applying the guidelines of (0.5) beds per 10,000 population in the service area of the proposal.

Response: Tables Eight-A and -B, beginning on the next page, present the above calculation based on CY2013 and CY2015 population projections for the primary and secondary service area counties.

The Tennessee population data are from the Tennessee Department of Health (Feb. 2008 series). The 2013 and 2015 Mississippi and Arkansas projections are made from U.S. Census data, based on annual increases projected by the Census between 2010 and 2011. The applicant used Census data for those States because neither has annual projections by county, that incorporate the 2010 U.S. Census data.

The tables indicate a total area population of 2,433,814 persons in CY2015 (Year Two of this project). Despite the Memphis LTACHs' extraordinarily high utilization (averaging 86.3%), the projection formula in this criterion A.1 indicates no additional LTACH bed need beyond currently operational and approved beds. This seems to conflict with the logical implications of Criterion A.2 immediately below, which suggests that additional beds may be needed once the service area's average LTACH occupancy reaches 85%--which this area consistently exceeds.

2. If the project is a bed addition, existing long term care hospital beds must have a minimum average occupancy of 85%.

Response: The three LTACH's in the service area reported a combined occupancy of 86.3% in the most recent reporting year; two of the three exceeded 86% and Select had a 94.6% occupancy. For the lowest-occupancy facility, its 75.5% occupancy rate needs an average daily census of only 2.8 patients to be at 85% occupancy, due to its very small bed complement.

3. The population shall be the current year's population, projected two years forward.

Response: The applicant's analysis for Criterion A.1 above did use the service area population projected two years from the effective date on which this application will begin its review process (i.e., CY2013 population projected to CY2015).

Table Eight-A: LTACH Bed Need, Guidelines for Growth 2000 Service Area of Select Specialty Hospital		
CY2015 Population	**LTACH Bed Need @ 0.5 per 10,000 Population**	**LTACH Beds Existing or Approved**
2,433,814	122 beds	105 + 24 u.c. = 129 beds

Table Eight-B : LTACH Bed Need, Guidelines for Growth 2000 Service Area of Select Specialty Hospital					
County	State	2010	2011	2013	2015
Shelby Co	TN	938,186	943,681	956,126	970,591
Benton Co	TN	16,657	16,680	16,779	16,903
Carroll Co	TN	29,631	29,734	29,970	30,243
Chester Co	TN	16,645	16,760	17,031	17,322
Crockett Co	TN	14,944	15,063	15,336	15,664
Decatur Co	TN	11,516	11,494	11,509	11,546
Dyer Co	TN	38,716	38,865	39,238	39,682
Fayette Co	TN	38,247	38,728	39,818	41,105
Gibson Co	TN	48,956	49,061	49,303	49,637
Hardeman Co	TN	29,491	29,738	30,299	30,941
Hardin Co	TN	26,741	26,846	27,091	27,402
Haywood Co	TN	19,662	19,678	19,786	19,949
Henderson Co	TN	27,584	27,767	28,170	28,626
Henry Co	TN	32,394	32,525	32,834	33,179
Lake Co	TN	7,423	7,407	7,393	7,386
Lauderdale Co	TN	27,888	28,127	28,641	29,220
Madison Co	TN	99,334	100,059	101,634	103,431
McNairy Co	TN	26,161	26,251	26,476	26,722
Obion Co	TN	32,626	32,675	32,839	33,061
Tipton Co	TN	61,300	62,102	63,857	65,839
Weakly Co	TN	33,799	33,841	33,970	34,152
Total TN		**1,577,901**	**1,587,082**	**1,608,100**	**1,632,601**
Alcorn Co	MS	37,057	37,052	37,042	37,032
Benton Co	MS	8,729	8,732	8,738	8,744
Coahoma Co	MS	26,151	25,913	25,437	24,961
DeSoto Co	MS	161,252	164,053	169,655	175,257
Itawamba Co	MS	23,401	23,332	23,194	23,056
Lafayette Co	MS	47,354	48,472	50,708	52,944
Lee Co	MS	82,910	84,156	86,648	89,140
Marshall Co	MS	37,144	36,786	36,070	35,354
Panola Co	MS	34,704	34,602	34,398	34,194
Pontotoc Co	MS	29,957	29,900	29,786	29,672
Prentiss Co	MS	25,276	25,330	25,438	25,546
Tate Co	MS	28,886	28,719	28,385	28,051
Tippah Co	MS	22,232	22,143	21,965	21,787
Tishomingo Co	MS	19,593	19,603	19,623	19,643
Tunica Co	MS	10,778	10,628	10,328	10,028
Union Co	MS	27,134	27,340	27,752	28,164
Total MS		**622,558**	**626,761**	**635,167**	**643,573**
Crittenden Co	AR	50,902	50,525	49,771	49,017
Lee Co	AR	10,424	10,326	10,130	9,934
Mississippi Co	AR	46,480	45,966	44,938	43,910
Monroe Co	AR	8,149	8,075	7,927	7,779
Phillips Co	AR	21,757	21,442	20,812	20,182
St Francis Co	AR	28,258	27,970	27,394	26,818
Total AR		**165,970**	**164,304**	**160,972**	**157,640**
Total Service Area		**2,366,429**	**2,378,147**	**2,404,239**	**2,433,814**

1 MS & AR 2010 & 2011 Data From State & County Quickfacts,
U.S. Census Bureau, 2012; 2013 & 2015 based on straight-line projections.
2 TN Projections from Tennessee Dept of Health.

4. The primary service area cannot be smaller than the applicant's Community Services Area (CSA). If LTH beds are proposed within an existing hospital, CSA's served by the existing facility can be included along with consideration for populations in adjacent States, when the applicant provides documentation (such as admission sources from the Joint Annual Report).

Response: The applicant has conformed its West Tennessee service area to the boundaries of the West Tennessee CSA's, almost all of whose counties are in the applicant's admissions-based service area anyway. Counties in Mississippi and Arkansas are included based on actual admissions from those out-of-State counties.

B. Economic Feasibility

1. The payer costs of a long term hospital should demonstrate a substantial saving, or the services should provide additional benefit to the patient over the payer cost or over the provision of short term general acute care alternatives, treating a similar patient mix of acuity.

Response: Table Nine on the next page compares the applicant's current gross charges per patient day to those of other LTACH hospitals in Shelby County. Charge per stay information is not relevant because of the wide variation in lengths of stay between the two types of hospital. Acuity information is not available. The difference in gross charge per patient day between LTACH's and general acute care (short term) hospitals is clearly substantial.

Table Nine: Comparative Charges Per Patient Day In Shelby County LTACH Facilities 2011 Joint Annual Reports / CN1210-052 (Mem.LT Care Spec'y)			
LTACH's	**Gross Inpatient Charges**	**IP or Discharge Days**	**Gross Charge Per Day**
Select Specialty CY 2011	$55,365,667	13,469	$4,111
Select Specialty CY 2015	$100,672,847	21,535	$4,675
Baptist Restor. Care CY2011	$44,353,983	8,267	$5,365
Methodist Ext. Care CY2011	$37,557,166	11,337	$3,313
Memph LT Care Spec CY2015	$28,143,153	8,322	$3,382
Average Gross Charge/Day, LTACH's in Shelby County	*$266,092,816*	*62,930*	*$4,228*
GENERAL HOSPITALS			
Baptist Memorial Hospital	$1,114,429,673	175,949	$6,334
Baptist Memorial Hospital Colliersville	$67,917,234	10,097	$6,726
Methodist Healthcare North	$368,520,300	58,820	$6,265
Methodist Healthcare South	$193,638,469	33,495	$5,781
Methodist Healthcare Germantown	$530,677,072	76,854	$6,905
Methodist LeBonheur Hospital	$436,975,498	56,884	$7,682
Methodist Healthcare University	$933,893,298	124,109	$7,525
Saint Francis Hospital	$812,315,392	89,083	$9,119
Saint Francis Hospital Bartlett	$281,098,187	29,947	$9,387
Delta Medical Center	$88,137,038	33,560	$2,626
The MED (Regl Med Center @ Mem)	$847,127,594	90,772	$9,332
Average Gross Charge/Day, General Hospitals in Shelby County	*$5,674,729,755*	*779,570*	*$7,279*

Source: Joint Annual Reports of Hospitals, 2011, pp. 18 & 24; CN1210-052 for Memphis Long Term Care Specialty Hospital; its data is for Year 1 (2015/16). Select Specialty data for 2015 is from this application.

2. The payer costs should be such that the facility will be financially accessible to a wide range of payers as well as to adolescent and adult patients of all ages.

Response: Adult (18+ years of age) patients enrolled in commercial, Medicare, and Medicaid insurance programs are served by this facility. Following is the payor mix of this facility, for CY2011 and YTD 2012.

Table Ten: Select Specialty Hospital-Memphis Payor Mix 2011 & YTD 2012		
Payor Classification	**CY2011**	**Q1-Q3, CY 2012**
Medicare	80.02%	79.39%
Medicaid	3.33%	3.40%
Commercial & WC	15.48%	16.74%
Other	1.17%	0.47%

Source: Select Specialty Corp. records

3. Provisions will be made so that a minimum of 5% of the patient population using long term care beds will be charity or indigent care.

Response: Line C.2 of the applicant's Historic and Projected Data Charts for the project do not reflect charity care to uninsured or underinsured persons per se, but the applicant does provide a substantial amount of uncompensated care.

Select Medical Corporation (the parent company) and its hospitals use the term "FLO" days (meaning "fixed loss outliers") to record these uncompensated days of care. Here is how uncompensated care is calculated: Each patient is assigned a Medicare DRG code at admission. That DRG has a specified payment, and has certain statistics considered normative based on national experience with that DRG. One statistic is the DRG's "geometric length of stay" ("GLOS")--the days of care that Medicare decides is appropriate for that DRG. The hospital is reimbursed at cost (calculated from its annual Medicare Cost Report) for each day of care provided, from admission until a patient stays 5/6 of that DRG's GLOS. At that point, the balance of the DRG is paid to the hospital. After that, if a patient needs more inpatient care beyond the 5/6 point, the hospital receives no reimbursement for a "fixed loss period" for that patient--similar to the "donut hole" for individual Medicare drug plans. The fixed loss is a specific dollar amount of free care that Medicare requires the hospital to provide before it resumes payments on

that patient. And once it does, Medicare begins to reimburse only at 80% of the hospital's cost of care—which further increases the free care by the hospital.

While this is not technically "charity" care, it is a necessary and substantial amount of free days of care contributed to many long-stay patients regardless of income. This uncompensated care is a large annual figure for Select. In 2011, more than a fifth (21%) of Select's total days were not reimbursed due to the FLO uncompensated care window applied by Medicare and other payors. The data in Table Eleven below show this facility's past three complete years of uncompensated days ("FLO days" that were incurrred. The Uncompensated Care column shows the applicant's gross charges during those days, minus any reimbursement later received for those patients after the fixed loss period ended. This is then shown as a percent of the hospital gross revenues. In the last full year (CY2011) Select provided this type of uncompensated care equal to 7.2% of hospital gross revenues. When 2012 data is compiled it will be similar to these years.

Table Eleven: Select Specialty Hospital-Memphis
Uncompensated Care Days From FLO Process

Year	FLO (Fixed Loss Outlier) Days	Uncompensated Care	As a Percent of Gross Revenue	As a Percent of Total Facility Days
2009	2,406	$3,644,232	7.4%	17.9%
2010	2,500	$3,349,049	6.7%	19.7%
2011	2,846	$3,970,854	7.2%	21.1%

Source: Hospital management

C. Orderly Development

1. (a) Services offered by the long term hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional nursing (requiring 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

(b) Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

(c) Also, to avoid unnecessary duplication, the project should include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term hospitals.

Responses:

(a) Select Specialty complies with this. It is located within a 24-hour hospital with a full array of acute care physician specialties available and on-call.

YTD 2012, Select has provided an average of 9.64 nursing hours per patient day (PPD), and 3.23 hours of therapies PPD, for a total of 12.87 hours PPD of nursing and therapeutic services. This greatly exceeds the 6-8 hours PPD recommended in this criterion--and illustrates the serious care requirements of this patient population. (Please see the Attachment labeled "Miscellaneous" for monthly data in nursing and therapeutic hours, CY2011 and CY2012 YTD.)

(b) Select Specialty provides care for the types of patients listed in this criterion: hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

(c) Select Specialty Hospital-Memphis has never, and will never, provide the referenced services or any other services not appropriate for long term acute care hospitals.

2. The applicant should provide assurance that the facility's patient mix will exhibit an annual average aggregate length of stay greater than 25 days, as calculated by the Health Care Finance Administration (HCFA), and will seek licensure only as a hospital.

Response: Table Twelve below provides documentation that this hospital's ALOS exceeds 25 days, and is projected to continue to exceed 25 days. See column five of the table.

Table Twelve: Historical and Projected Utilization Select Specialty Hospital-Memphis 2009-2012 Annualized					
Year	**Beds**	**Admissions**	**Days**	**Average Length of Stay (ALOS)**	**Occupancy**
CY2009	39	464	13,473	29.0	94.6%
CY2010	39	426	12,680	29.8	89.1%
CY2011	39	418	13,469	32.2	94.6%
CY2012 (ann'd)	39	466	13,357	28.7	93.8%
4-year Average	**39**	**444**	**13,425**	**30.2**	**93.0%**
CY2013	49	534	15,527	28.6	85.3%
CY2014 Yr 1	77	677	19,345	28.6	68.8%
CY2015 Yr 2	77	753	21,535	28.6	76.6%
CY2016 Yr 3	77	843	24,090	28.6	85.7%
CY2017 Yr 4	77	887	25,368	28.6	93.8%

Source: Joint Annual Reports; hospital records; management projections. Occupancy calculated on 365 days without leap year consideration. Admissions and ADC rounded.

3. The applicant should provide assurance that the projected caseload will require no more than three (3) hours per day of rehabilitation.

Response: Table Thirteen below provides nursing hours and rehabilitation hours per patient day for CY2011, and CY2012 YTD. Similar hours of rehabilitation PPD will be provided in the beds in this project. Monthly data for these calculations is provided in the Attachments (see "Miscellaneous").

Table Thirteen: Rehabilitation and Nursing Hours PPD Select Specialty Hospital-Memphis		
	Rehabilitation Hours Per Patient Day	**Nursing Hours Per Patient Day**
CY2011	3.23	9.64
CY2012 annualized	3.03	9.67

Source: Hospital records

4. Because of the very limited statewide need for long term care beds, and their overall high acuity of care, these beds should be allocated only to community service areas and be either inside or in close proximity to tertiary referral hospitals, to enhance physical accessibility to the largest concentration of services, patients, and medical specialists.

Response: The applicant is located within a CSA, is within a tertiary referral

hospital, and is within five miles of two other tertiary referral hospitals in Memphis—Baptist Hospital and Methodist Germantown.

5. In order to ensure that the beds and the facility will be used for the purpose certified, any Certificate of Need for a long term care hospital should be conditioned on the institution being certified by the Health Care Financing Administration as a long term hospital, and qualifying as PPS-exempt under applicable Federal guidelines. If such certification is received *(sic)* prior to the expiration date of the Certificate of Need, as provided in Tennessee Code Annotated(TCA) Section 68-11-108(c), the Certificate of Need shall expire, and become null and void.

Response: This condition is already met. The applicant is presently certified as a long-term hospital and qualified as PPS-exempt.

CMS is the Federal Center for Medicare/Medicaid Services; replacement for HCFA) In 2008, CMS placed a moratorium on Medicare certification of additional LTACH beds nationwide. This was extended once and is now scheduled to expire December 29, 2012. The Medicare moratorium may or may not be extended; but the applicant sees that as irrelevant to a CON decision on this application, because it is unpredictable and because Tennessee can license the beds it chooses regardless of the changing landscape in Medicare reimbursement. Providers should be enabled to use needed beds as soon as the moratorium is lifted, and not have to wait many months after that date, to complete a CON process. This problem can be resolved by granting a CON to operate additional licensed beds conditional on expiration of any CMS moratorium on certification of those beds.

The Framework for Tennessee's Comprehensive State Health Plan

Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.
Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

Select Specialty Hospital is one of only three existing LTACH providers that together operate 105 beds to serve patients of 43 counties in Tennessee and adjoining States. All three facilities serve an important role in working with general short term hospitals to relieve the latter of the financial burden of providing weeks of costly, uncompensated care to patients who need acute care beyond what the DRG will cover during a short term acute care stay. Individually, all of these three facilities operated at between approximately 85% and 95% occupancy in some, or all, of the past three years; and their most recently reported combined occupancy in CY2011 exceeded 86%. Select operated at 93.6% occupancy in CY2012, and had to defer many requests for admission. Collaboration with short term hospitals, to reduce costs of overall hospital care, requires available beds at the LTACH chosen by the patient and the discharging physician. This project supports that collaboration and supports this criterion of the State Health Plan.

2. Access to Care

Every citizen should have reasonable access to health care.
Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

The applicant believes that reasonable access to care requires some measure of choice for consumers and their families and physicians, and inpatient choice cannot occur without available bed space among a reasonable number of hospitals that are physically

and financially accessible. By allowing Select to license these proposed beds, access will be improved by the expansion of patient choice for residents of a vast service area of more than two million population. Current limitations of bed supply reduce patients' choices below what was available before area LTACH's became full.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

This project encourages the competition and efficiency goals of this criterion. It is efficient in that it avoids new hospital bed construction, relying instead on inexpensive renovation of existing beds that adjoin its existing facility. It promotes appropriate competition by recognizing and enabling the LTACH provider most in demand by area physicians and patients--a provider that has been full for four years now, and is appropriately seeking to expand.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

Select Specialty Hospital complies with quality standards and practices of the licensure program of the State of Tennessee and of its Joint Commission accreditation program.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

Select Specialty Hospital, like other hospitals, contributes to the education of health care professionals by its affiliations for training students in programs at several colleges and universities in Tennessee. See Section C.III. (6) of this application.

C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

This facility does not prepare formal long-range development plans.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

Select Specialty Hospital is the largest LTACH in Memphis. Like the tertiary Memphis hospital systems that provide many of its admissions, it serves a wide region of counties in several States around Memphis.

Select Specialty Hospital's admissions data indicate that it served residents of 78 counties in Tennessee, Mississippi, Arkansas, and eight other States. Its primary service area consisted of 17 contiguous counties in Tennessee, Arkansas, and Mississippi, whose residents generated 85% of its admissions. Its secondary service area consisted of another 26 contiguous counties in those States, generating another 11.2% of its admissions. Together, its primary and secondary service areas totaled 43 contiguous counties generating 96.3% of its admissions. Another 3.7% of admissions originated in 35 other non-contiguous counties in eight States.

The 43-county primary and secondary service areas are shown in Map One on the following page. The heaviest shaded counties are the primary service area; the lighter shaded counties are the secondary service area. The number of admissions from each county in the study period is shown. Following Map One, Table Fourteen lists the total service area counties.

With only a few exceptions, counties of fewer than 4 admissions were excluded from the primary and secondary service areas. Crockett and Chester Counties in West Tennessee were included in the declared project service area, because they are surrounded by service area counties and their inclusion is a reasonable and customary health planning practice when constructing a map of a project's contiguous service area counties. Also, those two counties plus Henry, Benton, and Decatur Counties in West Tennessee were included because Guideline for Growth #4 for LTACH beds requires inclusion of entire Tennessee CSA's (Community Service Areas) whose counties are being served.

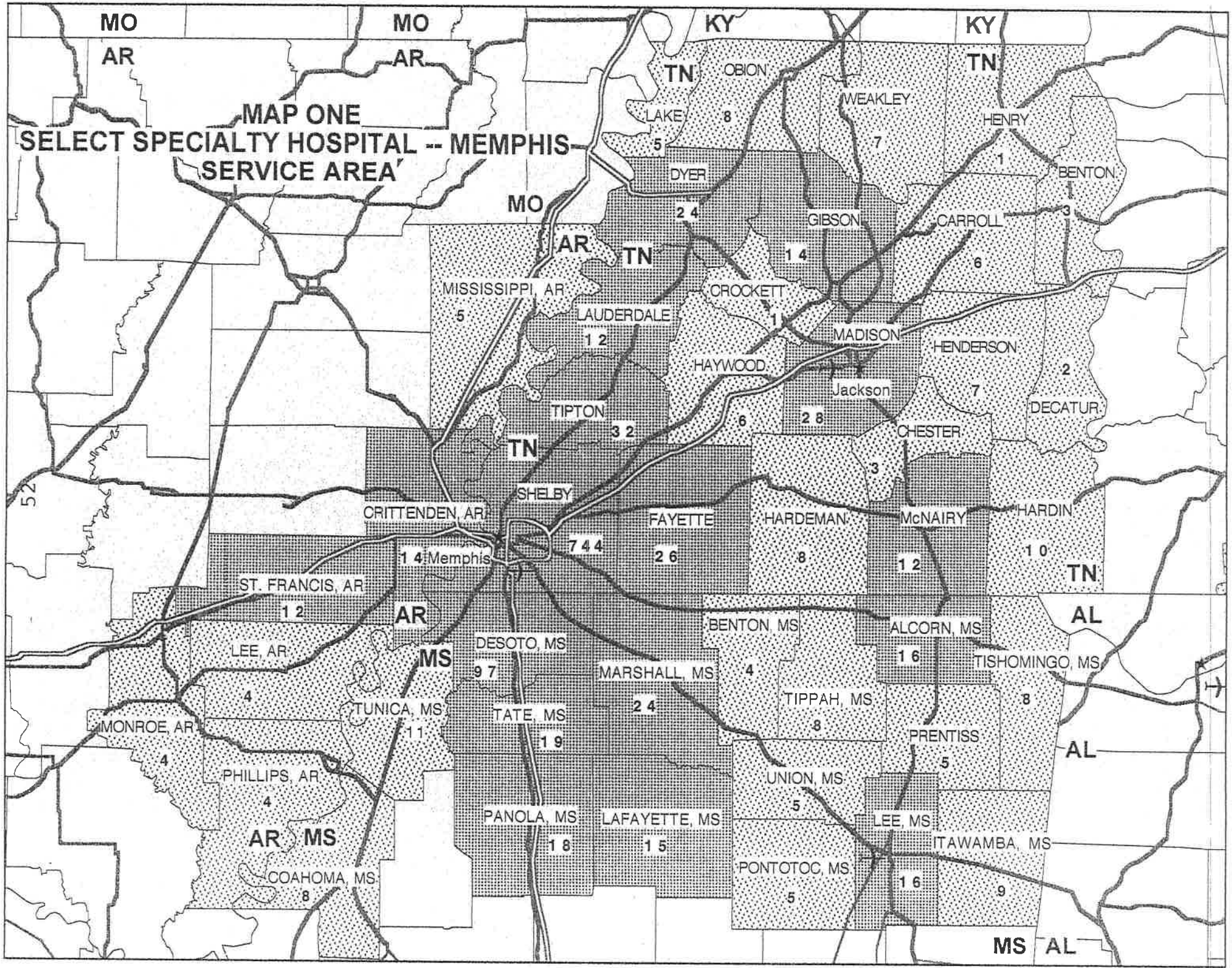

MAP ONE
SELECT SPECIALTY HOSPITAL -- MEMPHIS
SERVICE AREA
MO
AR
KY
TN
MS
AL
OBION
WEAKLEY
HENRY
BENTON
LAKE
DYER
GIBSON
CARROLL
MISSISSIPPI, AR
CROCKETT
LAUDERDALE
MADISON
HENDERSON
HAYWOOD
Jackson
DECATUR
TIPTON
CHESTER
SHELBY
CRITTENDEN, AR
FAYETTE
HARDEMAN
McNAIRY
HARDIN
Memphis
ST. FRANCIS, AR
BENTON, MS
ALCORN, MS
TISHOMINGO, MS
LEE, AR
DESOTO, MS
MARSHALL, MS
TIPPAH, MS
TUNICA, MS
TATE, MS
MONROE, AR
PRENTISS
PHILLIPS, AR
UNION, MS
PANOLA, MS
LAFAYETTE, MS
LEE, MS
ITAWAMBA, MS
COAHOMA, MS
PONTOTOC, MS
52

Table Fourteen: Service Area For Select Specialty Hospital-Memphis

Counties Ranked By Admissions

Primary Service Area		Discharges	Cumulative	Percent of Total
SHELBY, TENNESSEE	TN	744	744	56.1%
DESOTO, MISSISSIPPI	MS	97	841	63.8%
TIPTON, TENNESSEE	TN	32	873	66.2%
MADISON, TENNESSEE	TN	28	901	68.3%
FAYETTE, TENNESSEE	TN	26	927	70.3%
MARSHALL, MISSISSIPPI	MS	24	951	72.1%
DYER, TENNESSEE	TN	24	975	73.9%
TATE, MISSISSIPPI	MS	19	994	75.4%
PANOLA, MISSISSIPPI	MS	18	1012	76.7%
ALCORN, MISSISSIPPI	MS	16	1028	77.9%
LEE, MISSISSIPPI	MS	16	1044	79.2%
LAFAYETTE, MISSISSIPPI	MS	15	1059	80.3%
CRITTENDEN, ARKANSAS	AR	14	1073	81.3%
GIBSON, TENNESSEE	TN	14	1087	82.4%
SAINT FRAN, ARKANSAS	AR	12	1099	83.3%
LAUDERDALE, TENNESSEE	TN	12	1111	84.2%
MCNAIRY, TENNESSEE	TN	12	1123	85.1%
Secondary Service Area				
TUNICA, MISSISSIPPI	MS	11	1134	86.0%
HARDIN, TENNESSEE	TN	10	1144	86.7%
ITAWAMBA, MISSISSIPPI	MS	9	1153	87.4%
COAHOMA, MISSISSIPPI	MS	8	1161	88.0%
TIPPAH, MISSISSIPPI	MS	8	1169	88.6%
TISHOMINGO, MISSISSIPPI	MS	8	1177	89.2%
HARDEMAN, TENNESSEE	TN	8	1185	89.8%
OBION, TENNESSEE	TN	8	1193	90.4%
HENDERSON, TENNESSEE	TN	7	1200	91.0%
WEAKLEY, TENNESSEE	TN	7	1207	91.5%
CARROLL, TENNESSEE	TN	6	1213	92.0%
HAYWOOD, TENNESSEE	TN	6	1219	92.4%
MISSISSIPP, ARKANSAS	AR	5	1224	92.8%
PONTOTOC, MISSISSIPPI	MS	5	1229	93.2%
PRENTISS, MISSISSIPPI	MS	5	1234	93.6%
UNION, MISSISSIPPI	MS	5	1239	93.9%
LAKE, TENNESSEE	TN	5	1244	94.3%
LEE, ARKANSAS	AR	4	1248	94.6%
PHILLIPS, ARKANSAS	AR	4	1252	94.9%
BENTON, MISSISSIPPI	MS	4	1256	95.2%
MONROE, ARKANSAS	AR	4	1260	95.5%
BENTON, TENNESSEE	TN	3	1263	95.8%
CHESTER, TENNESSEE	TN	3	1266	96.0%
DECATUR, TENNESSEE	TN	2	1268	96.1%
CROCKETT, TENNESSEE	TN	1	1269	96.2%
HENRY, TENNESSEE	TN	1	1270	96.3%
Tertiary Service Area				
CRAIGHEAD, ARKANSAS	AR	3	1273	96.5%
GRENADA, MISSISSIPPI	MS	3	1276	96.7%
YALOBUSHA, MISSISSIPPI	MS	3	1279	97.0%
CROSS, ARKANSAS	AR	2	1281	97.1%
GREENE, ARKANSAS	AR	2	1283	97.3%
POINSETT, ARKANSAS	AR	2	1285	97.4%
CALHOUN, MISSISSIPPI	MS	2	1287	97.6%
CHICKASAW, MISSISSIPPI	MS	2	1289	97.7%
CLAY, MISSISSIPPI	MS	2	1291	97.9%
WASHINGTON, MISSISSIPPI	MS	2	1293	98.0%
COOK, ILLINOIS	OTHER-IL	2	1295	98.2%
CLAY, ARKANSAS	AR	1	1296	98.3%
CLEBURNE, ARKANSAS	AR	1	1297	98.3%
JEFFERSON, ARKANSAS	AR	1	1298	98.4%
LONOKE, ARKANSAS	AR	1	1299	98.5%
MARION, ARKANSAS	AR	1	1300	98.6%
WHITE, ARKANSAS	AR	1	1301	98.6%
FULTON, KENTUCKY	KY	1	1302	98.7%
JEFFERSON, KENTUCKY	KY	1	1303	98.8%
BOLIVAR, MISSISSIPPI	MS	1	1304	98.9%
HINDS, MISSISSIPPI	MS	1	1305	98.9%
JONES, MISSISSIPPI	MS	1	1306	99.0%
LEFLORE, MISSISSIPPI	MS	1	1307	99.1%
LOWNDES, MISSISSIPPI	MS	1	1308	99.2%
MONTGOMERY, MISSISSIPPI	MS	1	1309	99.2%
OKTIBBEHA, MISSISSIPPI	MS	1	1310	99.3%
QUITMAN, MISSISSIPPI	MS	1	1311	99.4%
PERSON, NORTH CAROLINA	NC	1	1312	99.5%
BROWARD, FLORIDA	OTHER-FL	1	1313	99.5%
OAKLAND, MICHIGAN	OTHER-MI	1	1314	99.6%
HOWELL, MISSOURI	OTHER-MO	1	1315	99.7%
CUMBERLAND, NORTH CAROLINA	OTHER-NC	1	1316	99.8%
DICKSON, TENNESSEE	TN	1	1317	99.8%
RUTHERFORD, TENNESSEE	TN	1	1318	99.9%
GIBSON, VIRGINIA	VA	1	1319	100.0%

Alphabetic By State and County

Primary Service Area		
CRITTENDEN, ARKANSAS	AR	14
SAINT FRAN, ARKANSAS	AR	12
ALCORN, MISSISSIPPI	MS	16
DESOTO, MISSISSIPPI	MS	97
LAFAYETTE, MISSISSIPPI	MS	15
LEE, MISSISSIPPI	MS	16
MARSHALL, MISSISSIPPI	MS	24
PANOLA, MISSISSIPPI	MS	18
TATE, MISSISSIPPI	MS	19
DYER, TENNESSEE	TN	24
FAYETTE, TENNESSEE	TN	26
GIBSON, TENNESSEE	TN	14
LAUDERDALE, TENNESSEE	TN	12
MADISON, TENNESSEE	TN	28
MCNAIRY, TENNESSEE	TN	12
SHELBY, TENNESSEE	TN	744
TIPTON, TENNESSEE	TN	32
Secondary Service Area		
LEE, ARKANSAS	AR	4
MISSISSIPP, ARKANSAS	AR	5
MONROE, ARKANSAS	AR	4
PHILLIPS, ARKANSAS	AR	4
BENTON, MISSISSIPPI	MS	4
COAHOMA, MISSISSIPPI	MS	8
ITAWAMBA, MISSISSIPPI	MS	9
PONTOTOC, MISSISSIPPI	MS	5
PRENTISS, MISSISSIPPI	MS	5
TIPPAH, MISSISSIPPI	MS	8
TISHOMINGO, MISSISSIPPI	MS	8
TUNICA, MISSISSIPPI	MS	11
UNION, MISSISSIPPI	MS	5
BENTON, TENNESSEE	TN	3
CARROLL, TENNESSEE	TN	6
CHESTER, TENNESSEE	TN	3
CROCKETT, TENNESSEE	TN	1
DECATUR, TENNESSEE	TN	2
HARDEMAN, TENNESSEE	TN	8
HARDIN, TENNESSEE	TN	10
HAYWOOD, TENNESSEE	TN	6
HENDERSON, TENNESSEE	TN	7
HENRY, TENNESSEE	TN	1
LAKE, TENNESSEE	TN	5
OBION, TENNESSEE	TN	8
WEAKLEY, TENNESSEE	TN	7

Source: Hospital records for CY2010-2012.

The declared 43-county service area is also validated by the fact that residents of almost all of its counties are closer to Select Specialty Hospital, than they are to LTACH's elsewhere.

In West and Middle Tennessee, the only LTACH facilities are in Memphis and Nashville. Only three of the twenty-one West Tennessee counties in this project's declared 43-county service area have shorter drive times to Nashville than to this project in Memphis. Similarly, all but two of the twenty-two Arkansas and Mississippi counties in the declared project service area are closer to Select Specialty Hospital than to LTACH's in their home states.

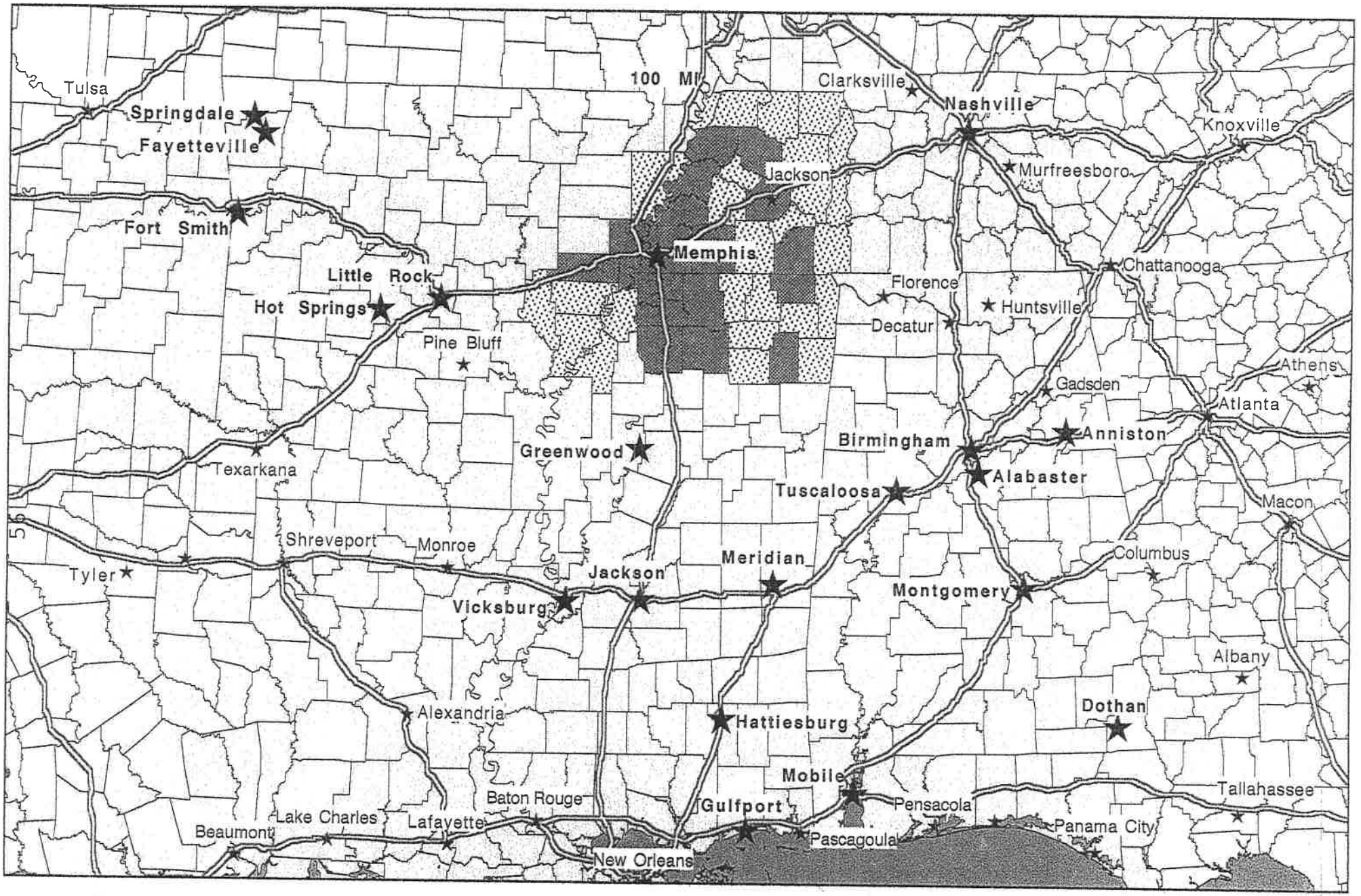
This is demonstrated by Table Fifteen on the following pages--listing the seventeen counties on the "perimeter" of the service area, which are closest to alternative LTACH's beyond this service area, in Nashville or adjoining States. Even in these perimeter counties, most residents have a shorter drive time to Memphis than to where the nearest alternative LTACH's are located. The shorter drive times for each comparison are bolded. And even for those few counties that are slightly closer to alternative LTACH's outside Memphis, there are special circumstances that justify their inclusion in a Memphis LTACH service area. Henry and Decatur County TN residents, for example, are much closer to Jackson tertiary care hospitals than to Nashville hospitals. If they seek hospital and specialty care in Jackson, many are more likely to be referred to Memphis than to Nashville, regardless of a small drive time differential. Similarly, Coahoma (Clarksdale) patients who typically seek care in Memphis will continue to drive the extra few miles to Memphis LTACH's than go to rural Mississippi for admission to the LTACH in rural Greenwood.

Further illustration that almost all these counties' access to Memphis is superior to their access to LTACH's in other locations is provided by Map Two on the second following page. Map Two has large stars marking the location of all alternative LTACH's in Mississippi, Arkansas, Alabama, and Middle and West Tennessee. (Small stars do not denote an LTACH). It can be seen that almost all the project service area counties are all closer to LTACH providers in Memphis than to LTACH's in any other city in these four States. Addresses of the alternative out-of-State LTACH's on Map Two are listed in the Attachments ("Miscellaneous").

Table Fifteen: Distance and Drive Times Between Counties on the Perimeter of the Project Service Area And The Closest Cities With Long Term Acute Care Hospitals

Service Area County (City)	Select Spec'y in Memphis TN		Cities With Alternative Long Term Acute Care Hospitals					
			Little Rock AR Cape Gir'x MO* Nashville TN**		Greenwood MS		Jackson MS	
	miles	minutes	miles	minutes	miles	minutes	miles	minutes
TENNESSEE								
Henry (Paris)*	132	139"	121	**122"****	--	--	--	--
Benton (Camden)*	136	**130"**	177	168"**	--	--	--	--
Decatur (Parsons)*	118	116"	97	**95"****	--	--	--	--
Hardin (Savannah)*	118	**124"**	118	126"**	--	--	--	
ARKANSAS								
Mississippi (Blytheville)*	68	**66"**	106"	102"*	--	--	--	--
Crittenden (Marion)					--	--	--	--
St. Francis (Forrest City)	65.2	**64"**	94.7	90"	--	--	--	--
Lee County (Marianna)	76.3	**83"**	99.5	104"	--	--	--	--
Monroe (Brinkley)	87.5	81"	69.1	**65"**	--	--	--	--
Phillips (Helena)	78.1	**88"**	122	129"	--	--	--	--
MISSISSIPPI								
Coahoma (Clarksdale)	83.8	96"	--	--	58	**69"**	155	169"
Panola (Batesville)	67.1	**65"**	--	--	71	74"	151	135"
Lafayette (Oxford)	70.6	**83"**	--	--	93.7	100"	173	160"
Pontotoc (Pontotoc)	92.7	**103"**	--	--	104	127"	125	137"
Lee (Tupelo)	101	**99"**	--	--	125	138"	190	189"
Itawamba (Fulton)	119	**119"**	--	--	148	160"	213	212"
Tishomingo (Luka)								

Source: Google Maps, December 2012



MAP TWO: LTACH LOCATIONS (LARGE STARS ONLY)
WEST TENNESSEE, ARKANSAS, MISSISSIPPI, & ALABAMA

C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

As shown by Table Sixteen on the following page, the eight Tennessee counties in the applicant's primary service area have a population of 1.3 million persons, which will increase approximately 3% over the next four years. This growth rate is slightly below the State's average 3.4% population growth rate.

The Tennessee primary service area is slightly less aged, and will remain so through 2017--but the percent of its population that is elderly is growing faster than in the State as a whole (13.5% increase vs. 12.4% increase Statewide), which eventually would erase the difference.

The primary service area has a higher percent of its population enrolled in TennCare, and a higher percent of persons below the poverty level, than the State average.

Table Sixteen: Demographic Characteristics of TN Primary Service Area Counties Of Select Specialty Hospital-Memphis 2013-2017

Demographic	SHELBY	DYER	FAYETTE	GIBSON	LAUDERDALE	MADISON	McNAIRY	TIPTON	PRIMARY SERVICE AREA	STATE OF TENNESSEE
Median Age-2010 US Census										38.0
Total Population-2013	956,126	39,238	39,818	49,303	28,641	101,634	26,476	63,857	1,305,093	6,361,070
Total Population-2017	983,298	40,042	41,841	49,878	29,626	104,914	26,908	67,365	1,343,872	6,575,165
Total Population-% Change 2013 to 2017	2.8%	2.0%	5.1%	1.2%	3.4%	3.2%	1.6%	5.5%	3.0%	3.4%
Age 65+ Population-2013	103,296	5,910	5,960	8,634	3,937	13,277	4,910	7,541	153,465	878,496
% of Total Population	10.8%	15.1%	15.0%	17.5%	13.7%	13.1%	18.5%	11.8%	11.8%	13.8%
Age 65+ Population-2017	118,044	6,515	7,093	9,081	4,442	15,013	5,290	8,748	174,225	987,074
% of Population	12.0%	16.3%	17.0%	18.2%	15.0%	14.3%	19.7%	13.0%	13.0%	15.0%
Age 65+ Population-% Change 2013-2017	14.3%	10.2%	19.0%	5.2%	12.8%	13.1%	7.7%	16.0%	13.5%	12.4%
Median Household Income	$46,102	$38,909	$57,437	$37,577	$34,078	$40,667	$34,953	$50,869	$42,574	$43,314
TennCare Enrollees (08/12)	231,988	9,467	5,686	11,115	7,326	21,161	7,017	11,615	305,375	1,211,113
Percent of 2012 Population Enrolled in TennCare	24.3%	24.1%	14.3%	22.5%	25.6%	20.8%	26.5%	18.2%	23.4%	19.0%
Persons Below Poverty Level (2012)	192,181	7,534	4,659	8,825	7,246	19,514	5,957	9,770	255,686	1,049,577
Persons Below Poverty Level As % of Population (US Census)	20.1%	19.2%	11.7%	17.9%	25.3%	19.2%	22.5%	15.3%	18.9%	16.5%

Sources: TDH Population Projections, Feb. 2008; U.S. Census QuickFacts and FactFinder2;
TennCare Bureau. PSA data is unweighted average or total of county data.
NR means not reported in U.S. Census source document.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

The service area population does not seem to have special care needs differing from those in other areas of Tennessee. Of all patients discharged from short term acute care stays in service area hospitals, there are always a small number who do not thrive. They require prolonged additional care in an acute care facility-- e.g., a "long term" acute care facility. Their stays average between three and four weeks, in accordance with Medicare expectations. The great majority (4 out of 5) are elderly, vulnerable, Medicare patients.

This project meets those patients' needs. Existing LTACH beds that serve this area are highly occupied, and have been highly occupied for at least four years. A newly approved Memphis LTACH, not yet under construction, seems to be ensured of immediate full occupancy, by patients in its host facility who have not been seeking admission to LTACH beds. The applicant believes that more LTACH beds are needed by residents in rural sectors of this service area. The project will provide needed care to such persons.

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

Table Seventeen on the following page presents 2009-2011 Joint Annual Report utilization data filed with the Department of Health by the three LTACH facilities in the service area. They are all in Memphis. The table provides licensed beds, admissions, patient/discharge days, ALOS, ADC, and occupancy for each facility, as well as the averages of those statistics for each year. Utilization of the LTACH provider group, led by Select Specialty, was very strong over the past three years. The most recent reported data for 2011 shows that:

- The average occupancy for service area LTACH's was 86.3% on licensed beds.

- That exceeds the Guidelines for Growth Criterion A.2 which recommends 85% areawide LTACH occupancy before additional LTACH beds are approved.

- Select's occupancy was the highest, at 94.6% of licensed beds.

- The second highest occupancy reported was 86.3%.

- Even the lowest occupancy facility reported almost 76% utilization.

Table Seventeen: Bed Utilization in Primary Service Area 2009-2011

2009 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Select Specialty Hospital--Memphis	Shelby	39	464	13,473	29	37	94.6%
	Baptist Memorial Restorative Care Hospital	Shelby	30	240	9,331	39	26	85.2%
	Methodist Extended Care Hospital	Shelby	36	425	11,757	28	32	89.5%
	SERVICE AREA TOTALS		**105**	**1,129**	**34,561**	31	95	90.2%

2010 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Select Specialty Hospital--Memphis	Shelby	39	426	12,680	30	35	89.1%
	Baptist Memorial Restorative Care Hospital	Shelby	30	236	8,015	34	22	73.2%
	Methodist Extended Care Hospital	Shelby	36	419	11,379	27	31	86.6%
	SERVICE AREA TOTALS		**105**	**1,081**	**32,074**	30	88	83.7%

2011 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Select Specialty Hospital--Memphis	Shelby	39	418	13,469	32	37	94.6%
	Baptist Memorial Restorative Care Hospital	Shelby	30	207	8,267	40	23	75.5%
	Methodist Extended Care Hospital	Shelby	36	434	11,337	26	31	86.3%
	SERVICE AREA TOTALS		**105**	**1,059**	**33,073**	31	91	86.3%

C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION. THE METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

Table Eighteen below shows the facility's historical utilization 2009-2012, and management's projections for its utilization through CY2017, which will be Year Four of this project. Select Specialty Hospital management has experienced extraordinarily high demand for its beds for the past four years, averaging 93% occupancy on 39 beds. Due to lack of bed space, Select has had to deny requests for qualified admissions during 17 of the past 22 months. Select does not maintain logs of "unduplicated patient" admissions requests. But during most months, an average of a dozen requests for admissions must be deferred for lack of bed space.

As Select expands its outreach marketing in Mississippi, Arkansas, and rural West Tennessee in CY2013, additional admissions demand is predictable. With its proposed additional beds, Select projects that between 2012 and 2015 (Year Two) its admissions will increase by an average of approximately 96 new admissions per year, and its average daily census will increase by an average of approximately 7 per year.

Table Eighteen: Historical and Projected Utilization
Select Specialty Hospital-Memphis
2009-2012 Annualized

Year	Beds	Admissions	Days	Average Daily Census	Occupancy
CY2009	39	464	13,473	37	94.6%
CY2010	39	426	12,680	35	89.1%
CY2011	39	418	13,469	37	94.6%
CY2012 (ann'd)	39	466	13,357	37	93.8%
4-year Average	**39**	**444**	**13,425**	**37**	**93.0%**
CY2013	49	534	15,527	43	85.3%
CY2014 Yr 1	77	677	19,345	53	68.8%
CY2015 Yr 2	77	753	21,535	59	76.6%
CY2016 Yr 3	77	843	24,090	66	85.7%
CY2017 Yr 4	77	887	25,368	70	93.8%

Source: Joint Annual Reports; hospital records; management projections. Occupancy calculated on 365 days without leap year consideration. Admissions and ADC rounded.

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

• ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST $3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.

• THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.

• THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.

• FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The letter supporting the construction cost estimate is being submitted to the Agency under separate cover, to be placed in Attachment C, Economic Feasibility--1.

On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the Development staff of Select Medical Corporation.

Line A.2, legal, administrative, and consultant fees, were estimated by the Development staff of Select Medical Corporation and the CON consultant.

Line A.5, construction cost, was estimated not to exceed $95 PSF for all clinical areas of the 11th floor (excluding elevators, etc.) This includes a construction contingency.

Line A.7 includes both fixed and moveable equipment costs, estimated by Select Medical Corporation's equipment planning staff.

Line A.9 includes such costs as miscellaneous minor equipment and furnishings, miscellaneous fees and overhead, IT, and telecommunications.

Line B.1 is the fair market value of the facility being leased, calculated in the two alternative ways required by staff rules. The market value of the space was the larger of these two alternative calculations and was used in the Project Cost Chart.

Lease Outlay Method:

5 years first lease extension term; additional rent for 28 beds = $2,421,184

Pro Rata Building Value Method:

$150 PSF estimated depreciated value X 21,677 SF leased = $3,251,550

PROJECT COSTS CHART--BED EXPANSION FOR SELECT SPECIALTY HOSPITAL MEMPHIS

A.	Construction and equipment acquired by purchase:			
1.	Architectural and Engineering Fees	6.5%xA.5	$	133,855
2.	Legal, Administrative, Consultant Fees (Excl CON Filing)			55,000
3.	Acquisition of Site			0
4.	Preparation of Site			0
5.	Construction Cost	$95 PSF X 21,677 PSF		2,059,315
6.	Contingency Fund	in A.5		0
7.	Fixed Equipment (Not included in Construction Contract)			0
8.	Moveable Equipment (List all equipment over $50,000)			1,263,185
9.	Other (Specify) IT, telecommun, etc			120,000
B.	Acquisition by gift, donation, or lease:			
1.	Facility (inclusive of building and land)			3,251,550
2.	Building only			0
3.	Land only			0
4.	Equipment (Specify)			0
5.	Other (Specify)			0
C.	Financing Costs and Fees:			
1.	Interim Financing			0
2.	Underwriting Costs			0
3.	Reserve for One Year's Debt Service			0
4.	Other (Specify)			0
D.	Estimated Project Cost (A+B+C)			6,882,905
E.	CON Filing Fee			15,487
F.	Total Estimated Project Cost (D+E)		TOTAL $	6,898,392
			Actual Capital Cost	3,646,842
			Section B FMV	3,251,550

C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).

_____A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

_____B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

_____C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

_____D. Grants--Notification of Intent form for grant application or notice of grant award;

__x___E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

_____F. Other--Identify and document funding from all sources.

The project will be funded/financed by the hospital, from reserves available currently. Documentation of intent to finance is provided in Attachment C, Economic Feasibility--2. The hospital's income statement and balance sheet are also provided in the Attachments.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The justification of costs was provided in an earlier section, which is repeated below.

This project is more economical than most. By comparison, the estimated $2,059,315 remodeling/renovation cost for the project is projected to be only $95 PSF. The 2009-2011 acute care construction projects approved by the HSDA had the costs per SF shown in Table Three below. This project's $95 PSF cost is below even 1st quartile averages for renovation ($125 PSF).

Table Four: Hospital Construction Cost PSF
Years: 2009 – 2011

	Renovated Construction	New Construction	Total Construction
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$125.84/sq ft	$324.00/sq ft	$301.74/sq ft

Source: CON approved applications for years 2009 through 2011

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable. Select has provided Projected Data Charts for the 28 beds being requested, and also for the entire 77 bed facility when the 28 beds are opened. Itemization of the "other" expenses listed on both historical and projected charts is provided on a single sheet following the data charts.

HISTORICAL DATA CHART -- SELECT SPECIALTY HOSPITAL MEMPHIS (39 BEDS)

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in JANUARY.

		CY 2009	CY2010	CY2011
A.	Utilization Data (JAR discharge days) & Occupancy	13,473 / 94.6%	12,680 / 89.1%	13,470 / 94.6%
B.	Revenue from Services to Patients			
1.	Inpatient Services	$ 48,966,179	50,227,911	55,365,667
2.	Outpatient Services			
3.	Emergency Services			
4.	Other Operating Revenue (rental & interest income)	79,722	25,093	23,599
	(Specify) See notes			
	Gross Operating Revenue	$ 49,045,901	$ 50,253,004	$ 55,389,266
C.	Deductions for Operating Revenue			
1.	Contractual Adjustments	$ 27,550,747	29,520,092	34,254,860
2.	Provision for Charity Care (see notes)			
3.	Provisions for Bad Debt	196,718	245,189	651,376
	Total Deductions	$ 27,747,465	$ 29,765,281	$ 34,906,236
	NET OPERATING REVENUE	$ 21,298,436	$ 20,487,723	$ 20,483,030
D.	Operating Expenses			
1.	Salaries and Wages	$ 8,641,388	8,604,828	8,821,665
2.	Physicians Salaries and Wages	0	0	0
3.	Supplies	2,240,036	2,316,600	2,426,988
4.	Taxes	1,234,633	1,259,246	1,361,619
5.	Depreciation	147,159	105,836	79,709
6.	Rent	392,898	575,151	643,405
7.	Interest, other than Capital	1,234	0	0
8.	Management Fees			
	a. Fees to Affiliates	1,571,477	1,223,660	1,257,018
	b. Fees to Non-Affiliates	0	0	0
9.	Other Expenses (Specify) See notes	3,878,534	4,519,743	4,803,389
	Total Operating Expenses	$ 18,107,359	18,605,064	19,393,793
E.	Other Revenue (Expenses) -- Net (Specify)	$	$	$
	NET OPERATING INCOME (LOSS)	$ 3,191,077	$ 1,882,659	$ 1,089,237
F.	Capital Expenditures			
1.	Retirement of Principal	$ 0	$ 0	$ 0
2.	Interest	0	0	0
	Total Capital Expenditures	$ 0	$ 0	$ 0
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$ 3,191,077	$ 1,882,659	$ 1,089,237

PROJECTED DATA CHART—SELECT SPECIALTY HOSPITAL MEMPHIS (28 BEDS)

Give information for the two (2) years following the completion of this proposal.
The fiscal year begins in January.

			Year 2014	Year 2015
		Admissions	143	218
A.	Utilization Data	Patient Days	4,088	6,241
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 18,561,633	$ 29,145,658
	2. Outpatient Services			
	3. Emergency Services			
	4. Other Operating Revenue (Specify)			
		Gross Operating Revenue	$ 18,561,633	$ 29,145,658
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 12,139,708	$ 19,260,772
	2. Provision for Charity Care			
	3. Provisions for Bad Debt		147,705	227,353
		Total Deductions	$ 12,287,413	$ 19,488,125
NET OPERATING REVENUE			$ 6,274,220	$ 9,657,533
D.	Operating Expenses			
	1. Salaries and Wages		$ 2,524,940	$ 4,202,548
	2. Physicians Salaries and Wages			
	3. Supplies		683,120	1,046,201
	4. Taxes	38.5% avg 09-11	171,224	321,213
	5. Depreciation		313,099	313,100
	6. Rent		442,585	455,863
	7. Interest, other than Capital			
	8. Management Fees			
	a. Fees to Affiliates	6% assumed	376,453	579,452
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes	1,489,285	2,226,050
		Total Operating Expenses	$ 6,000,706	$ 9,144,427
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 273,514	$ 513,106
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 273,514	$ 513,106

PROJECTED DATA CHART--SELECT SPECIALTY HOSPITAL MEMPHIS (77 BEDS)

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

			Year 2014	Year 2015
A.	Utilization Data	Admissions	677	753
		Patient Days	19,345	21,535
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 87,875,704	$ 100,672,847
	2. Outpatient Services			
	3. Emergency Services			
	4. Other Operating Revenue (Specify)			
		Gross Operating Revenue	$ 87,875,704	$ 100,672,847
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 57,572,330	$ 66,547,039
	2. Provision for Charity Care			
	3. Provisions for Bad Debt		696,978	784,894
		Total Deductions	$ 58,269,308	$ 67,331,933
NET OPERATING REVENUE			$ 29,606,396	$ 33,340,914
D.	Operating Expenses			
	1. Salaries and Wages		$ 13,053,243	$ 14,860,264
	2. Physicians Salaries and Wages			
	3. Supplies		3,405,684	3,786,145
	4. Taxes	38.5% avg 09-11	871,781	1,046,702
	5. Depreciation		458,291	472,577
	6. Rent		1,217,585	1,254,113
	7. Interest, other than Capital			
	8. Management Fees			
	a. Fees to Affiliates	6% assumed	1,776,384	2,000,455
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes	7,430,843	8,248,654
		Total Operating Expenses	$ 28,213,811	$ 31,668,910
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 1,392,585	$ 1,672,004
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 1,392,585	$ 1,672,004

Other Expenses (Line D.8)	HISTORICAL 39 BEDS			PROJECTION 28 BEDS				PROJECTION 77 BEDS			
	2009	2010	2011	Year 1	Year 2	Year 3	Year 4	Year 1	Year 2	Year 3	Year 4
Insurance	90,177	103,968	114,612	24,581	44,212	65,407	73,703	155,678	176,687	198,949	209,799
Utilities	28,729	25,870	32,564	60,984	62,839	64,750	66,719	162,624	177,709	183,114	198,822
Legal & Accounting	47,872	43,931	37,401	10,286	18,501	27,370	30,842	65,146	73,937	83,253	87,794
Repairs & Maintenance	135,452	255,634	114,629	40,261	72,415	107,130	120,718	254,985	289,396	325,859	343,631
Travel/Meals & Entertainment	230,685	223,143	225,357	54,071	97,256	143,878	162,127	342,451	388,665	437,636	461,504
Contracted Physicians	72,620	66,215	146,606	22,724	40,874	60,468	68,137	143,922	163,344	183,925	193,956
Ancillary Patient Services	2,699,937	3,072,318	3,357,487	1,044,527	1,603,788	2,225,401	2,515,522	4,943,096	5,533,789	6,223,838	6,572,775
Equipment Rentals	303,945	492,203	507,552	170,330	175,510	180,848	186,349	973,311	1,002,915	1,033,419	1,052,685
Corporate Services	269,117	236,462	267,181	61,521	110,655	163,701	184,464	389,631	442,213	497,931	525,087
Total Other (D.9)	3,878,534	4,519,743	4,803,389	1,489,285	2,226,050	3,038,953	3,408,581	7,430,843	8,248,654	9,167,925	9,646,053

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Nineteen: Average Charges, Deductions, Net Charges, Net Operating Income 28 Additional Beds		
	CY2014	**CY2015**
Patient **Days**	**4,088**	**6,241**
Admissions or Discharges	143	218
Average Gross Charge **Per Day**	**$4,541**	**$4670**
Average Gross Charge Per Admission	$129,802	$133,696
Average Deduction from Operating Revenue/**Day**	**$3,006**	**$3,123**
Average Deduction from Operating Revenue/Admission	$85,926	$89,395
Average Net Charge (Net Operating Revenue)/**Day**	**$1,535**	**$1547**
Average Net Charge (Net Operating Revenue)/Admission	$43,876	$44,301
Average Net Operating Income after Expenses/**Day**	**$67**	**$82**
Average Net Operating Income after Expenses/Admission	$1,913	$2,354

Table Twenty: Average Charges, Deductions, Net Charges, Net Operating Income 77 Total Beds		
	CY2014	**CY2015**
Patient **Days**	**19,345**	**21,535**
Admissions or Discharges	677	753
Average Gross Charge **Per Day**	**$4,543**	**$4,675**
Average Gross Charge Per Admission	$129,802	$133,696
Average Deduction from Operating Revenue/**Day**	**$3,012**	**$3,127**
Average Deduction from Operating Revenue/Admission	$86,070	$89,418
Average Net Charge (Net Operating Revenue)/**Day**	**$1,530**	**$1,548**
Average Net Charge (Net Operating Revenue)/Admission	$43,732	$44,277
Average Net Operating Income after Expenses/**Day**	**$72**	**$78**
Average Net Operating Income after Expenses/Admission	$2057	$2,220

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

Please see Table Twenty-One on the following page. It shows the gross charge and DRG payment for the most frequent admissions of this hospital.

The renovation project will not have any adverse impact on gross patient charges, which increased approximately 3% from 2010 to 2011, and are projected to increase approximately that amount annually, whether or not the project is implemented.

Table Twenty-One: Charge Data for Most Frequent Types of Admission
Select Specialty Hospital--Memphis

Service: Long Term Hospital Care

DRG	Descriptor	Current Medicare DRG	Average Gross Charge		
			Current	Year 1	Year 2
207	Respiratory system diagnosis w ventilator support 96+ hours	75,187.05	162,337	167,207	172,223
189	Pulmonary Edema & respiratory failure	35,833.94	79,332	81,712	84,163
208	Respiratory system diagnosis w ventilator support <96 hours	41,606.91	69,884	71,981	74,140
539	Osteomyelitis w MCC	40,083.86	78,718	81,080	83,512
592	Skin Ulcers w MCC	33,491.68	74,819	77,064	79,376
949	Aftercare w CC/MCC	27,257.18	52,266	53,834	55,449
981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	81,389.05	230,798	237,722	244,854
4	Trach w MV 96+ hours or PDX exc face, mouth & neck w/o major OR	114,586.31	208,712	214,974	221,423
559	Aftercare, musculoskeletal system & connective tissue w MCC	35,360.87	86,742	89,345	92,025
870	Septicemia or severe sepsis w MV 96+ hours	79,713.89	178,621	183,980	189,499
3	ECMO or trach w MV 96+ hours or PDX exc face, mouth & neck w maj O.R.	159,754.69	377,125	388,439	400,092
314	Other circulatory system diagnosis w MCC	37,095.46	85,573	88,141	90,785
463	WND Debrid & skin graft exc hand, for musculo-conn tissue dis w MCC	55,745.11	181,628	187,077	192,689
871	Septicemia or severe sepsis w/o MV 96+ hours w MCC	33,772.44	65,758	67,730	69,762
638	Diabetes w CC	27,687.94	58,137	59,881	61,678
	All Others	22,454.60	53,581	55,188	56,844

Source: Hospital management

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

The requested Medicare comparison is provided in the table on the preceding page. The table below compares the most recently reported gross charge data for the two operating LTACH's and a third approved LTACH in this service area.

Table Twenty-Two: Comparative Charges Per Patient Day In Shelby County LTACH Facilities 2011 Joint Annual Reports / CN1210-052 (Mem.LT Care Spec'y)

LTACH's	Gross Inpatient Charges	IP or Discharge Days	Gross Charge Per Day
Select Specialty CY 2011	$55,365,667	13,469	$4,111
Select Specialty CY 2015	$100,672,847	21,535	$4,675
Baptist Restor. Care CY2011	$44,353,983	8,267	$5,365
Methodist Ext. Care CY2011	$37,557,166	11,337	$3,313
Memph LT Care Spec CY2015	$28,143,153	8,322	$3,382
Average Gross Charge/Day, LTACH's in Shelby County	*$266,092,816*	*62,930*	*$4,228*
GENERAL HOSPITALS			
Baptist Memorial Hospital	$1,114,429,673	175,949	$6,334
Baptist Memorial Hospital Colliersville	$67,917,234	10,097	$6,726
Methodist Healthcare North	$368,520,300	58,820	$6,265
Methodist Healthcare South	$193,638,469	33,495	$5,781
Methodist Healthcare Germantown	$530,677,072	76,854	$6,905
Methodist LeBonheur Hospital	$436,975,498	56,884	$7,682
Methodist Healthcare University	$933,893,298	124,109	$7,525
Saint Francis Hospital	$812,315,392	89,083	$9,119
Saint Francis Hospital Bartlett	$281,098,187	29,947	$9,387
Delta Medical Center	$88,137,038	33,560	$2,626
The MED (Regl Med Center @ Mem)	$847,127,594	90,772	$9,332
Average Gross Charge/Day, General Hospitals in Shelby County	*$5,674,729,755*	*779,570*	*$7,279*

Source: Joint Annual Reports of Hospitals, 2011, pp. 18 & 24; CN1210-052 for Memphis Long Term Care Specialty Hospital; its data is for Year 1 (2015/16). Select Specialty data for 2015 is from this application.

C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

The hospital is already cost-effective and operates with a positive financial margin. Additional census will support continued financial viability.

C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

The hospital operates with a positive financial margin. Additional census will support continued financial viability. Cash flow is not an issue; this is an existing facility with established reimbursement and positive cash flow at all times.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

The hospital in Q1-Q3 2012 had a payor mix of 80.02% Medicare, 3.3% Medicaid, 15.48% Commercial and Workmen's Comp, and 1.3% other. The projections assume that the Medicare and Medicaid payor mix will remain the same though CY2015.

Table Twenty-Three: Select Specialty Hospital-Memphis Medicare and Medicaid Gross Revenue (28-bed P&L) Year One (CY2014)	
Total Gross Revenue	$18,561,633
Medicare Gross Revenue	$14,853,019
% of Gross Revenue	80.02%
Medicaid Gross Revenue	$618,102
% of Gross Revenue	3.33%

Source: Hospital records.

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:

A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.

B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

The alternative of not adding beds at this location was rejected for several reasons. First, the hospital has coped with very high 93% occupancy and routine deferrals of qualified admissions for several years--due to lack of bed space. It is appropriate to respond to this demand without more delay. Second, the availability of beds for conversion, immediately below the existing LTACH floor, offers a feasible opportunity to expand the operation efficiently without relocation or new construction, at a low capital cost. Third, visits to hospitals and physicians in the outlying counties of the service area have convinced hospital management that significant latent additional need for long term acute inpatient care exists there, which Select can meet if it undertakes the approved and proposed bed expansions that will utilize the 11th floor.

The alternative of delaying for the MED's new LTACH to meet market demand was not a reasonable one. The MED's representatives have told the HSDA that the MED's own internal demand for these beds, from patients not now using LTACH beds in the community, is more than enough to completely fill the 24 beds being acquired and moved to the MED campus. That leaves the three existing LTACH's to meet other service area hospitals' needs. Being the most highly utilized of the three, and having no information about the intent or ability of the other two LTACH's to expand as economically at their present locations, Select feels that this proposed expansion is timely and is the best alternative for the service area.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

Select Specialty Hospital is located within the tertiary Saint Francis Hospital. Saint Francis is its "host", in LTACH language. Select contracts with the host hospital and the host's vendors to deliver the ancillary and support services needed by its patients. This includes food and janitorial services, diagnostic imaging and testing, surgery if required, and health professional consults and support on a 24-hour basis. The latter includes all types of physician services that may be needed.

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

Select Specialty Hospital does not project that the project will have any significant or persistent impact on the other existing or approved LTACH providers in this vast 43-county service area.

The preceding response indicated why this project should have no impact on the MED's intended operation of 24 LTACH beds on its campus (they will be completely utilized by MED patients who are not now using LTACH care; and there are sufficient numbers of those patients in the MED to utilize even more beds than the MED has proposed).

With respect to the Baptist and Methodist LTACH's, Select works well with both healthcare systems and believes that their LTACH facilities enjoy high occupancy and a strong positive margin that will not be reduced significantly by Select's provision of beds to meet Select's own demonstrated admissions needs.

There is no way to quantify the impact exactly, but Select believes it would be small, and of short duration. Select anticipates drawing most of its new patients from large hospital providers outside of Memphis, who do not yet have strong referral relationships with hospital systems in Memphis. Currently, eleven hospitals routinely refer patients to Select Specialty Hospital. Management has begun field visits that will result in additional hospitals starting to refer patients routinely to Select in Memphis.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

See Table Twenty-Four below for data from the Tennessee Department of Labor and Workforce Development. See the following page for Table Twenty-Five, showing current and projected FTE's and salary ranges for this project.

Table Twenty-Four: TDOL Surveyed Average Hourly Salaries for the Region

Position	Entry Level	Mean	Median	Experienced
RN	23.55	31.70	29.35	35.80
LPN	15.90	19.05	18.90	20.65
CNA	8.95	11.10	10.90	12.20
PT	31.25	40.95	39.75	45.80
PTA	21.10	28.20	29.95	31.75
OT	27.30	35.80	36.05	40.05
Resp. Therapist	19.85	23.55	23.50	25.40
Speech Therap.	22.80	31.35	30.10	35.60
Pharmacist	45.15	55.50	57.65	60.65
Pharmacy Tech	8.90	11.30	11.15	12.50

Source: 2012 Salary Surveys, Memphis Area, TN Dept of Labor & Workforce Dev'mt

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

Please see the following page for Table Twenty-Five, showing projected FTE's and salary ranges for the project. Current staffing is included.

Table Twenty-Five: Select Specialty Hospital--Memphis Addition of Licensed Beds Current and Projected Staffing					
Position Type (RN, etc.)	Current FTE's	Year One Projected FTE's	Year Two Projected FTE's	Change, Year Two from Current	Salary Range (Hourly)
Admissions Coordinator	2.0	2.0	2.0	-	$ 16.14
Case Management Secretary	1.0	1.0	1.0	-	$ 13.18
Case Manager	1.0	3.0	3.0	2.0	$ 34.02
Clinical Liaison	4.0	4.0	4.0	-	$ 29.34
C.N.A.	30.6	41.6	46.3	15.7	$ 11.33
HIM Tech	2.0	2.0	2.0	-	$ 14.66
Infection Control	1.0	1.5	1.6	0.6	$ 35.00
LPN	3.0	-	-	(3.0)	$ 20.88
Materials Tech	1.0	1.0	1.5	0.5	$ 17.48
Monitor Tech	4.7	4.7	4.7	-	$ 12.50
Non-Clinical	6.0	6.0	6.0	-	$ 37.51
Occupational Therapy	2.0	3.0	3.0	1.0	$ 45.00
Pharmacist	4.0	4.0	4.0	-	$ 54.28
Pharmacy Tech	1.0	2.4	2.5	1.5	$ 18.15
PT	1.0	2.0	2.0	1.0	$ 40.58
PT Assistant	2.0	2.0	2.0	-	$ 29.01
RN	39.6	56.8	62.9	23.3	$ 32.36
Respiratory Therapist	13.6	18.5	20.6	7.0	$ 22.50
Speech Pathologist	1.0	2.0	2.0	1.0	$ 38.57
Staffing Coordinator	1.0	1.0	1.0	-	$ 11.00
Unit Secretary	4.7	9.4	9.4	4.7	$ 11.53
Wound Care Specialist	2.0	2.0	2.5	0.5	$ 31.66
Total FTE's	128.2	167.9	181.5	55.8	

Source: Hospital Management

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

Select Specialty Hospital-Memphis provides a very attractive work environment and anticipates having no difficulty in staffing the proposed beds. As a licensed facility Select is well aware of, and complies with, State and professional staffing standards and requirements.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

At the time of this application, Select Specialty has no formal contracts under which health professions programs rotate students through the facility for training.

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION

LICENSURE: Board for Licensure of Healthcare Facilities
Tennessee Department of Health

CERTIFICATION: Medicare Certification from CMS
TennCare Certification from TDH

ACCREDITATION: Joint Commission

C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission on Accreditation of Healthcare Organizations.

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

Not applicable. The applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

March 27, 2013

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	3	4-2013
2. Construction documents approved by TDH	48	5-2013
3. Construction contract signed	53	5-2013
4. Building permit secured	54	5-2013
13	na	na
6. Building construction commenced	67	6-2013
7. Construction 40% complete	123	8-2013
8. Construction 80% complete	183	10-2013
9. Construction 100% complete	203	12-2013
10. * Issuance of license	218	12-2013
11. *Initiation of service	233	1-2014
12. Final architectural certification of payment	293	3-2014
13. Final Project Report Form (HF0055)	323	4-2014

*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

INDEX OF ATTACHMENTS

A.4--Ownership
Legal Entity, Licensure, Accreditation

Board for Licensing Health Care Facilities

State of Tennessee

0000000147

No. of Beds 0039

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

SELECT SPECIALTY HOSPITAL - MEMPHIS, INC. *to conduct and maintain a*

Hospital SELECT SPECIALTY HOSPITAL - MEMPHIS

Located at 5959 PARK AVENUE, 12TH FLOOR, MEMPHIS

County of SHELBY *, Tennessee.*

This license shall expire NOVEMBER 23 , 2013 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 1ST *day of* JULY , 2012 .

In the Distinct Category(ies) of: CHRONIC DISEASE HOSPITAL

By Vincent J. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By [signature] MD

COMMISSIONER

92

SELECT SPECIALTY HOSPITAL - MEMPHIS, INC.

Rocco A. Ortenzio, Sole Director
c/o Select Medical Corporation
4718 Old Gettysburg Road
P.O. Box 2034
Mechanicsburg, PA 17055

Rocco A. Ortenzio, Chairman & CEO
c/o Select Medical Corporation
4718 Old Gettysburg Road
P. O. Box 2034
Mechanicsburg, PA 17055

Robert A. Ortenzio, President
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Michael E. Tarvin, Vice President
and Secretary
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Scott A. Romberger, Vice President,
Treasurer and Assistant Secretary
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Kenneth L. Moore, Vice President
and Assistant Secretary
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Patricia A. Rice, Vice President
c/o Select Medical Corporation
4718 Old Gettysburg Road, P. O. Box 2034
Mechanicsburg, PA 17055

Stevan B. Baird, Vice President
c/o Select Medical Corporation
4718 Old Gettysburg Road
P. O. Box 2034
Mechanicsburg, PA 17055

STATE OF TENNESSEE

HEALTH FACILITIES COMMISSION

Certificate of Need CN9406-032A is hereby granted under the provisions of T.C.A. §68-11-101, *et seq.*, and the rules and regulations issued thereunder by this Commission

to AMISUB (SFH) d/b/a Saint Francis Hospital

for St. Francis Hospital

This Certificate is issued for the establishment of a thirty (30) bed long-term care hospital; forty-two (42) medical/surgical beds will simultaneously be delicensed.

CONDITION: Approval subject to Health Care Financing Administration (HCFA) certification as a Long Term Care Hospital

on the premises located at 5959 Park Avenue
Memphis, TN 38119-5198

for an estimated project cost of $562,000.00

The Expiration Date for this Certificate of Need is

November 1, 1997

or upon completion of the action for which the Certificate of Need was granted, whichever occurs first. After the effective date, this Certificate of Need is null and void.

Date Approved September 28, 1994

Date Issued October 31, 1994

*Date Reissued: March 6, 1997

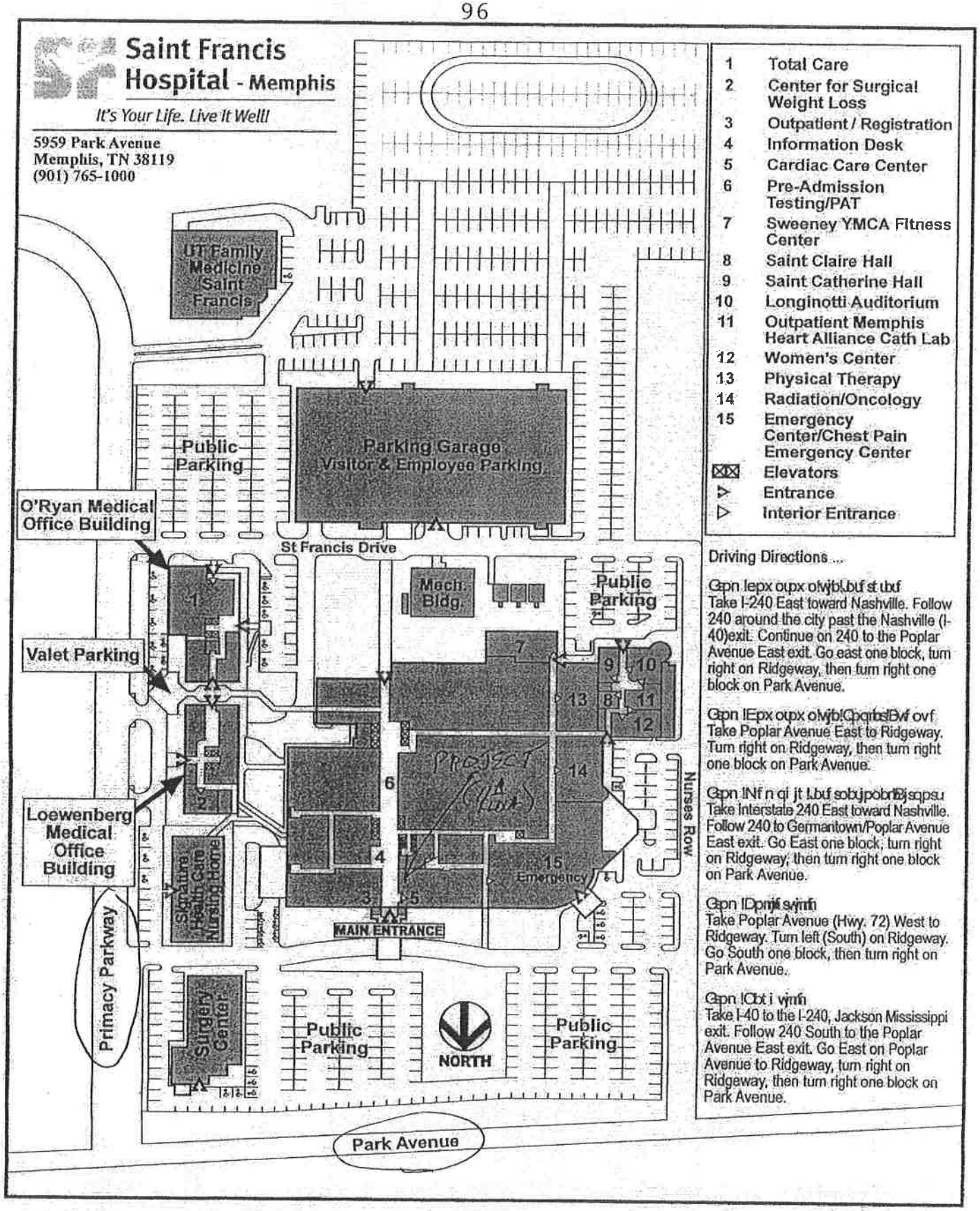
* Certificate was reissued to reflect new owner

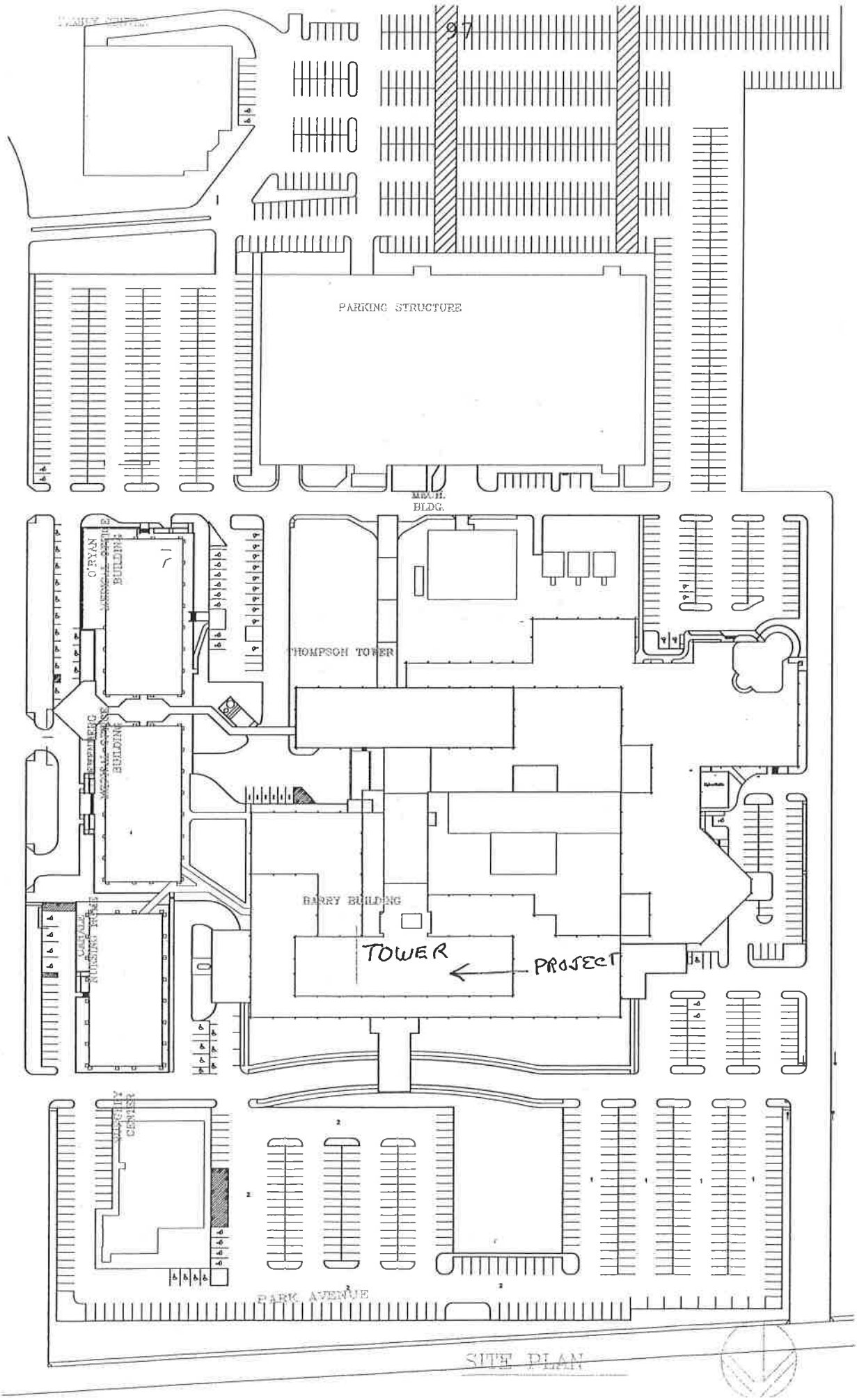
Chairman

Secretary

HF-0022 (Rev. 5-93)

B.III.--Plot Plan

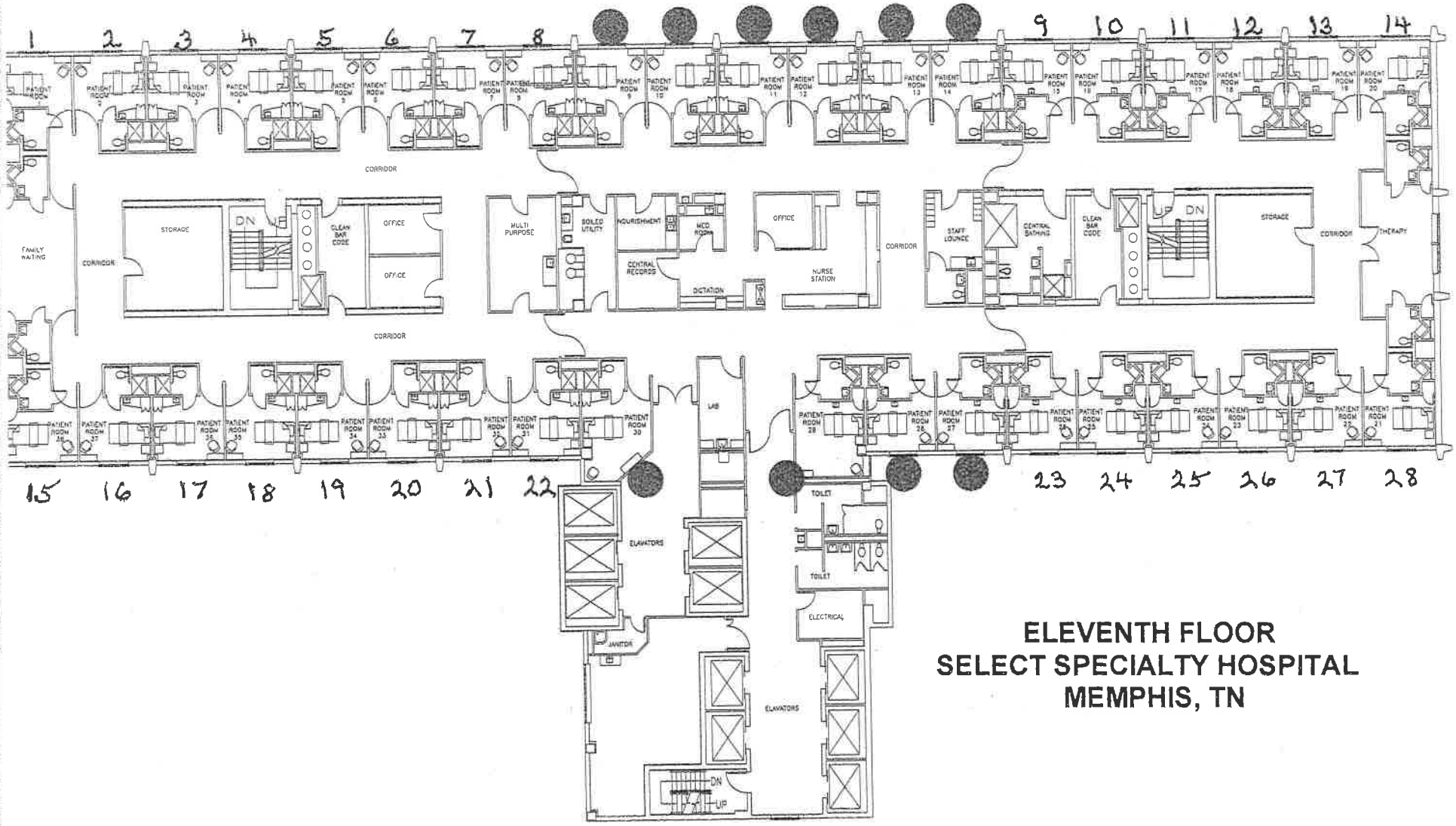

Saint Francis Hospital - Memphis
It's Your Life. Live It Well!
5959 Park Avenue
Memphis, TN 38119
(901) 765-1000
UT Family Medicine / Saint Francis
Public Parking
Parking Garage Visitor & Employee Parking
O'Ryan Medical Office Building
St Francis Drive
Mech. Bldg.
Public Parking
Valet Parking
Loewenberg Medical Office Building
Sunshine Health Care Nursing Home
Nurses Row
MAIN ENTRANCE
Emergency
Primacy Parkway
Surgery Center
Public Parking
NORTH
Public Parking
Park Avenue
1 Total Care
2 Center for Surgical Weight Loss
3 Outpatient / Registration
4 Information Desk
5 Cardiac Care Center
6 Pre-Admission Testing/PAT
7 Sweeney YMCA Fitness Center
8 Saint Claire Hall
9 Saint Catherine Hall
10 Longinotti Auditorium
11 Outpatient Memphis Heart Alliance Cath Lab
12 Women's Center
13 Physical Therapy
14 Radiation/Oncology
15 Emergency Center/Chest Pain Emergency Center
Elevators
Entrance
Interior Entrance
Driving Directions ...
Take I-240 East toward Nashville. Follow 240 around the city past the Nashville (I-40)exit. Continue on 240 to the Poplar Avenue East exit. Go east one block, turn right on Ridgeway, then turn right one block on Park Avenue.
Take Poplar Avenue East to Ridgeway. Turn right on Ridgeway, then turn right one block on Park Avenue.
Take Interstate 240 East toward Nashville. Follow 240 to Germantown/Poplar Avenue East exit. Go East one block, turn right on Ridgeway, then turn right one block on Park Avenue.
Take Poplar Avenue (Hwy. 72) West to Ridgeway. Turn left (South) on Ridgeway. Go South one block, then turn right on Park Avenue.
Take I-40 to the I-240, Jackson Mississippi exit. Follow 240 South to the Poplar Avenue East exit. Go East on Poplar Avenue to Ridgeway, turn right on Ridgeway, then turn right one block on Park Avenue.


97
PARKING STRUCTURE
MECH.
BLDG.
O'RYAN
BUILDING
THOMPSON TOWER
BARRY BUILDING
TOWER
PROJECT
PARK AVENUE

SITE PLAN

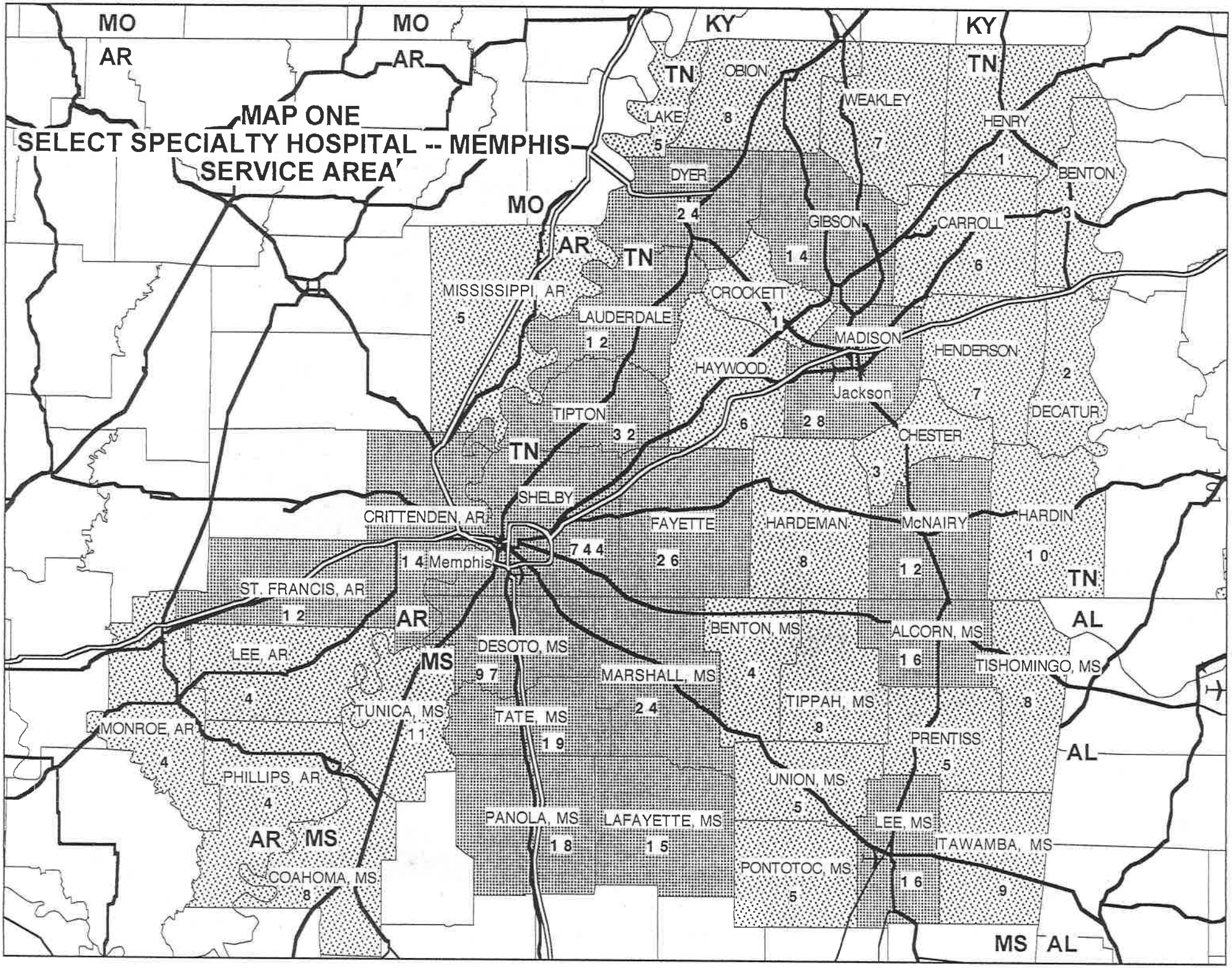
B.IV.--Floor Plan

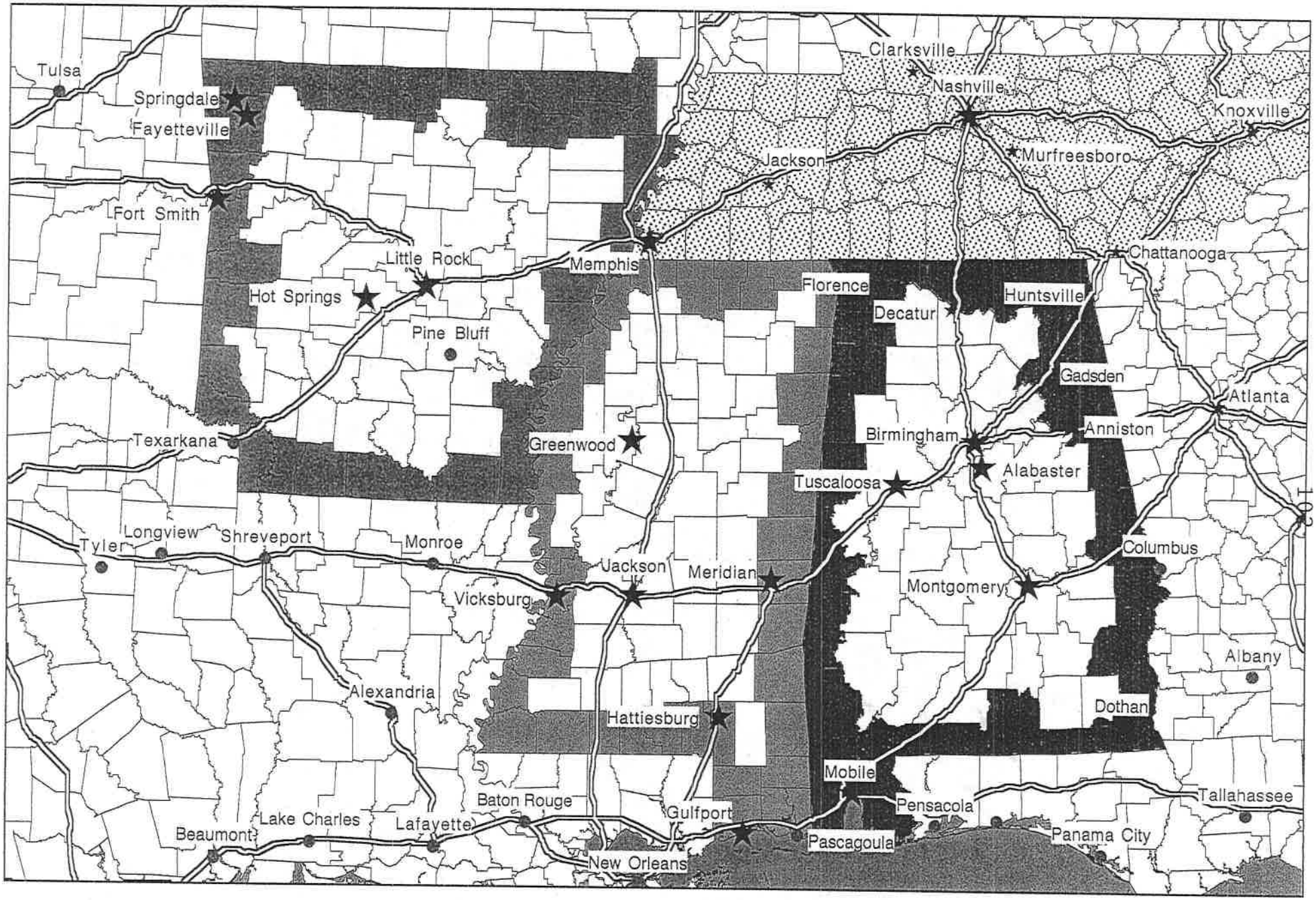
● = 10 LTACH BEDS ALREADY APPROVED FOR LICENSURE (EARLY 2013)
NUMBERED ROOMS = 28 ADDITIONAL LTACH BEDS PROPOSED IN THIS APPLICATION



ELEVENTH FLOOR
SELECT SPECIALTY HOSPITAL
MEMPHIS, TN

C, Need--3
Service Area Maps


MAP ONE
SELECT SPECIALTY HOSPITAL -- MEMPHIS
SERVICE AREA
MO
AR
KY
TN
MS
AL
OBION
LAKE
5
8
WEAKLEY
7
HENRY
1
BENTON
3
DYER
2 4
GIBSON
1 4
CARROLL
6
MISSISSIPPI, AR
5
CROCKETT
1
LAUDERDALE
1 2
MADISON
HENDERSON
2
HAYWOOD
Jackson
7
DECATUR
TIPTON
3 2
6
2 8
CHESTER
3
SHELBY
CRITTENDEN, AR
FAYETTE
2 6
HARDEMAN
8
McNAIRY
1 2
HARDIN
1 0
7 4 4
1 4 Memphis
ST. FRANCIS, AR
1 2
BENTON, MS
ALCORN, MS
1 6
TISHOMINGO, MS
LEE, AR
4
DESOTO, MS
9 7
MARSHALL, MS
2 4
4
TIPPAH, MS
8
8
TUNICA, MS
1 1
TATE, MS
1 9
MONROE, AR
4
PRENTISS
5
PHILLIPS, AR
4
UNION, MS
5
PANOLA, MS
1 8
LAFAYETTE, MS
1 5
LEE, MS
ITAWAMBA, MS
COAHOMA, MS
8
PONTOTOC, MS
5
1 6
9



SERVICE AREA LOCATION
STATE OF TENNESSEE

C, Economic Feasibility--2
Documentation of Availability of Funding

Select MEDICAL
Improving Quality of Life

Martin F. Jackson
Executive Vice President,
Chief Financial Officer

December 14, 2012

Melanie M. Hill, Executive Director
Tennessee Health Facilities Commission
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

Dear Mrs. Hill:

Select Specialty Hospital – Memphis, Inc. is applying for a Certificate of Need to lease, remodel, and license 28 additional inpatient beds leased from Saint Francis Hospital in Memphis, on its 11th floor. This will require a capital expenditure of no more than approximately $3,647,000.

As Chief Financial Officer for Select Medical Corporation, the corporate parent of Select Specialty Hospital – Memphis, Inc., I am writing to confirm that Select Specialty Hospital – Memphis, Inc. will fund the project in cash, and that it currently has sufficient cash reserves and operating income to do so.

Sincerely,

Martin F. Jackson
Executive Vice President & CFO

4714 Gettysburg Road • P.O. Box 2034 • Mechanicsburg, PA 17055
mjackson@selectmedical.com • 717.972.3814 • Fax 717.303.0824

C, Economic Feasibility--10
Financial Statements

ORACLE Applications

Y YTD BALANCE SHEET REPORT

lect Medical Corporation
od: DEC-11 Currency: USD
Submitted: 07-DEC-12 15:30:11

COMPANY=422 (Memphis)

	CY2011
Current assets:	
Cash and cash equivalents	0.00
Accounts receivables:	
Patient receivables	10,493,753.77
AR Clearing	(2,453,433.93)
Contractual adjustments	(5,392,725.56)
Allow for doubtful accounts	(494,989.28)
Other receivables	0.00
Prepaid expenses	0.00
Other current assets	123,990.33
Total current assets	2,276,595.33
Affiliates:	
Investments in	0.00
Advances to	15,264,421.30
Total affiliates	15,264,421.30
Property and equipment:	
Land	0.00
Building and improvements	754,831.67
Assets under capital leases	0.00
Furniture and equipment	1,195,159.07
Asset Clearing	0.00
Total fixed assets	1,949,990.74
Less accum. deprec	(1,709,409.17)
Net val property, plant & equip	240,581.57
Construction in progress	0.00
Total property, plant & equip	240,581.57
Other assets:	
Deposits	5,653.12
Prepaid rent	0.00
Goodwill, net	0.00
Other intangibles	0.00
Mgmt service agreements	0.00
Long term investments	0.00
Notes receivable	0.00
Deferred costs, net	0.00
Deferred financing costs, net	0.00
Other noncurrent assets	1,853.34
Total noncurrent assets	7,506.46
Total assets	17,789,104.66
Current liabilities:	
Notes payable	
Current portion of L-T debt:	
Seller notes - current	0.00
Notes and mortgages	0.00
Capital leases	0.00
Accounts payable	933,632.71
Accrued expenses:	
Payroll	0.00
Vacation	197,845.86
Insurance	0.00
Other	83,204.97
Due to third party payor	(1,489,005.02)
Income taxes:	
Current	0.00
Deferred	0.00
Total current liabilities	(274,321.48)
L-T debt, net of current portion:	
Notes, mortgages & conv. debt	0.00
Seller notes - LT	0.00
Subordinate debt	0.00
Credit facility debt	0.00
Capital leases	0.00
Other liabilities:	
Deferred income taxes	0.00
Other L-T liabilities	0.00
Total L-T debt & liab	0.00
Minority interest:	
Capital	0.00
Retained earnings	0.00
Total minority interest	0.00
Shareholders & partners equity:	
Common stock	0.00
Preferred stock (Class A)	0.00
Preferred stock (Class B)	0.00

COMPANY=422 (Memphis)

	CY2011
Preferred stock dividends	0.00
Distributions	0.00
Capital in excess of par	3,034,876.27
Retained earnings, prior	11,331,175.76
Current year net income (loss)	3,697,374.11
Total S & P equity	18,063,426.14
Total liabilities & equity	17,789,104.66

COMPANY=422 (Memphis)

	YTD ACTUAL 2011 Jan-Dec
CMI Medicare MTD	
CMI Medicare YTD	
Equivalent Patient Days	13,198.00
Average Daily Census	36.16
IP Physician Rounds	0.00
REVENUES	
Inpatient Routine	10,665,184.00
Inpatient Ancillary	44,700,483.47
Outpatient Ancillary	0.00
Total Patient Revenues	55,365,667.47
DEDUCTIONS FROM REVENUE	
Contractual Allowance	23,456,363.78
Contracted Discounts	10,670,361.59
Prior Year Contractual Adj	109,795.26
Other Revenue Deductions	18,339.10
Total Revenue Deductions	34,254,859.73
NET PATIENT REVENUE	21,110,807.74
Other Revenue	6,742.31
TOTAL NET REVENUE	21,117,550.05
OPERATING EXPENSES	
Salaries & Wages	7,338,941.56
Benefits	1,482,723.18
Contracted Departments	3,357,486.49
Physician Fees	146,606.00
Medical Supplies	2,303,936.51
Food & Other Supplies	123,051.65
Equipment Leases & Rentals	507,551.75
Other Fees	37,401.12
Data Processing Fees	0.00
Repairs & Maintenance	114,628.80
Utilities	32,564.21

COMPANY=422 (Memphis)

	YTD ACTUAL 2011 Jan-Dec
Insurance	114,612.00
Taxes, Non-Income	(9,499.99)
Other Expenses	225,356.82
Bad Debt Expenses	651,376.45
Corporate Services	267,180.38
Total Operating Expenses	16,693,916.93
NET OPERATING PROFIT	4,423,633.12
CONTRIBUTION MARGIN %	20.95%
CAPITAL COSTS	
Interest	0.00
Depreciation	79,239.36
Amortization	0.00
Facility/Office Lease	643,404.68
Property Taxes	20,001.00
Corporate Services Capital	469.87
Total Capital Costs	743,114.91
TOTAL COSTS	17,437,031.84
PRE-TAX/MGMT FEE	3,680,518.21
Management Fee	0.00
PRE-TAX/INTEREST	3,680,518.21
Intercompany Interest	(16,653.10)
Other Interest Income	(202.80)
PRE-TAX/MINORITY INT	3,697,374.11
Minority Interest	0.00
PRE-TAX PROFIT	3,697,374.11
Income Taxes	0.00
NET INCOME	3,697,374.11

COMPANY=422 (Memphis)

	YTD ACTUAL 2012 Jan-Oct
REVENUES	
Inpatient Routine	10,730,880.00
Inpatient Ancillary	38,409,511.40
Outpatient Ancillary	0.00
Total Patient Revenues	49,140,391.40
DEDUCTIONS FROM REVENUE	
Contractual Allowance	22,146,112.68
Contracted Discounts	9,162,123.41
Prior Year Contractual Adj	148,276.21
Other Revenue Deductions	70,040.80
Total Revenue Deductions	31,526,553.10
NET PATIENT REVENUE	17,613,838.30
Other Revenue	853.80
TOTAL NET REVENUE	17,614,692.10
OPERATING EXPENSES	
Salaries & Wages	6,550,500.46
Benefits	1,273,331.57
Contracted Departments	2,911,404.01
Physician Fees	124,028.00
Medical Supplies	1,875,330.03
Food & Other Supplies	119,020.81
Equipment Leases & Rentals	565,143.35
Other Fees	38,015.60
Data Processing Fees	0.00
Repairs & Maintenance	76,813.50

COMPANY=422 (Memphis)

	YTD ACTUAL 2012 Jan-Oct
Utilities	72,637.79
Insurance	97,294.80
Taxes, Non-Income	(6,100.63)
Other Expenses	232,617.33
Bad Debt Expenses	406,979.00
Corporate Services	262,937.17
Total Operating Expenses	14,599,952.79
NET OPERATING PROFIT	3,014,739.31
CONTRIBUTION MARGIN %	17.11%
CAPITAL COSTS	
Interest	0.00
Depreciation	54,303.09
Amortization	0.00
Facility/Office Lease	540,605.39
Property Taxes	16,064.55
Corporate Services Capital	0.00
Total Capital Costs	610,973.03
TOTAL COSTS	15,210,925.82
PRE-TAX/MGMT FEE	2,403,766.28
Management Fee	0.00
PRE-TAX/INTEREST	2,403,766.28
Intercompany Interest	(17,580.28)
Other Interest Income	(4.39)
PRE-TAX/MINORITY INT	2,421,350.95
Minority Interest	0.00
PRE-TAX PROFIT	2,421,350.95
Income Taxes	0.00
NET INCOME	2,421,350.95

ORACLE Applications

Y YTD BALANCE SHEET REPORT

lect Medical Corporation
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Submitted: 07-DEC-12 15:30:32

COMPANY=422 (Memphis)

	YTD 2012-Jan-Oct
Current assets:	
Cash and cash equivalents	0.00
Accounts receivables:	
Patient receivables	9,101,848.53
AR Clearing	(1,435,951.72)
Contractual adjustments	(4,523,218.76)
Allow for doubtful accounts	(685,939.78)
Other receivables	0.00
Prepaid expenses	0.00
Other current assets	145,124.39
Total current assets	2,601,862.66
Affiliates:	
Investments in	0.00
Advances to	14,814,575.74
Total affiliates	14,814,575.74
Property and equipment:	
Land	0.00
Building and improvements	754,831.67
Assets under capital leases	0.00
Furniture and equipment	1,248,912.96
Asset Clearing	0.00
Total fixed assets	2,003,744.63
Less accum. deprec	(1,761,722.64)
Net val property, plant & equip	242,021.99
Construction in progress	0.00
Total property, plant & equip	242,021.99
Other assets:	
Deposits	5,653.12
Prepaid rent	0.00
Goodwill, net	0.00
Other intangibles	0.00
Mgmt service agreements	0.00
Long term investments	0.00
Notes receivable	0.00
Deferred costs, net	0.00
Deferred financing costs, net	0.00
Other noncurrent assets	1,853.34
Total noncurrent assets	7,506.46
Total assets	17,665,966.85
Current liabilities:	
Notes payable	
Current portion of L-T debt:	
Seller notes - current	0.00
Notes and mortgages	0.00
Capital leases	0.00
Accounts payable	1,109,599.81
Accrued expenses:	
Payroll	0.00
Vacation	190,846.57
Insurance	0.00
Other	112,906.39
Due to third party payor	(1,825,872.01)
Income taxes:	
Current	0.00
Deferred	0.00
Total current liabilities	(412,519.24)
L-T debt, net of current portion:	
Notes, mortgages & conv. debt	0.00
Seller notes - LT	0.00
Subordinate debt	0.00
Credit facility debt	0.00
Capital leases	0.00
Other liabilities:	
Deferred income taxes	0.00
Other L-T liabilities	0.00
Total L-T debt & liab	0.00
Minority interest:	
Capital	0.00
Retained earnings	0.00
Total minority interest	0.00
Shareholders & partners equity:	
Common stock	0.00
Preferred stock (Class A)	0.00
Preferred stock (Class B)	0.00

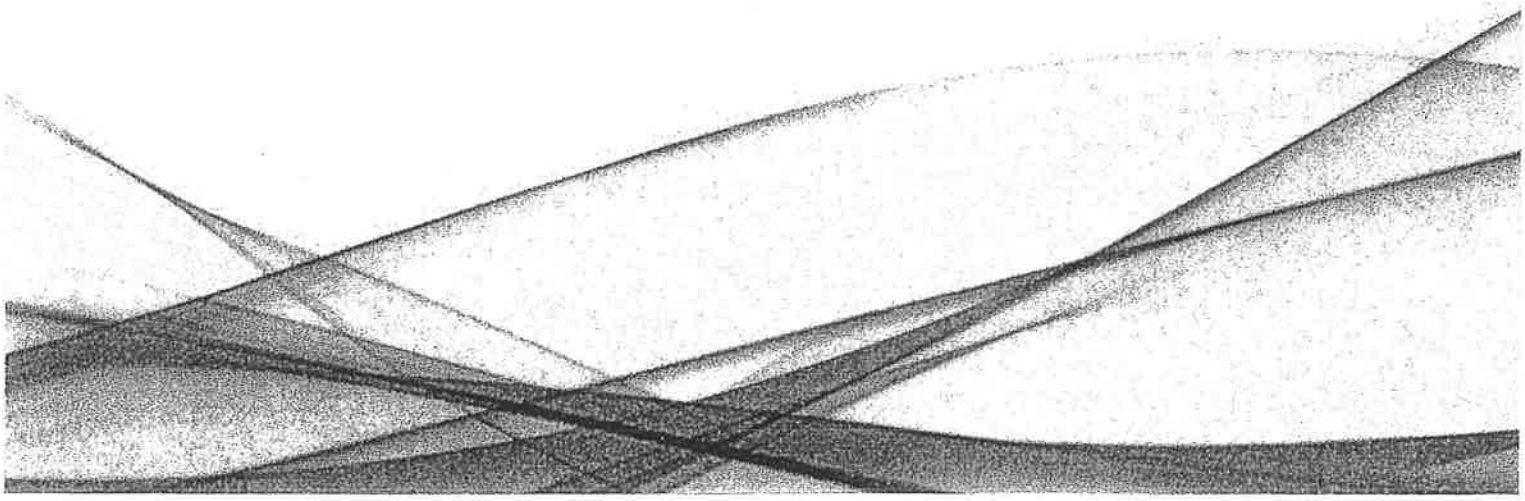
COMPANY=422 (Memphis)

	YTD 2012-Jan-Oct
Preferred stock dividends	0.00
Distributions	0.00
Capital in excess of par	3,034,876.27
Retained earnings, prior	12,622,258.87
Current year net income (loss)	2,421,350.95
Total S & P equity	18,078,486.09
Total liabilities & equity	17,665,966.85

SELECT MEDICAL HOLDINGS CORPORATION

2011 ANNUAL REPORT

Select MEDICAL
Improving Quality of Life



Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholder
of Select Medical Corporation:

In our opinion, the consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of Select Medical Corporation and its subsidiaries at December 31, 2011 and December 31, 2010, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2011 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedule, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedule, and on the Company's internal control over financial reporting based on our audits (which were integrated audits in 2011 and 2010). We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania
March 2, 2012

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders
of Select Medical Holdings Corporation:

In our opinion, the consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of Select Medical Holdings Corporation and its subsidiaries at December 31, 2011 and December 31, 2010, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2011 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedule, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedule, and on the Company's internal control over financial reporting based on our audits (which were integrated audits in 2011 and 2010). We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania
March 2, 2012

PART I *FINANCIAL INFORMATION*

ITEM 1. *CONSOLIDATED FINANCIAL STATEMENTS*

Consolidated Balance Sheets
(in thousands, except share and per share amounts)

	Select Medical Holdings Corporation		Select Medical Corporation	
	December 31, 2010	December 31, 2011	December 31, 2010	December 31, 2011
ASSETS				
Current Assets:				
Cash and cash equivalents	$ 4,365	$ 12,043	$ 4,365	$ 12,043
Accounts receivable, net of allowance for doubtful accounts of $44,416 and $47,469 in 2010 and 2011, respectively	353,432	413,743	353,432	413,743
Current deferred tax asset	30,654	18,305	30,654	18,305
Prepaid income taxes	12,699	9,497	12,699	9,497
Other current assets	28,176	29,822	28,176	29,822
Total Current Assets	429,326	483,410	429,326	483,410
Property and equipment, net	532,100	510,028	532,100	510,028
Goodwill	1,631,252	1,631,716	1,631,252	1,631,716
Other identifiable intangibles	80,119	72,123	80,119	72,123
Assets held for sale	11,342	2,742	11,342	2,742
Other assets	37,947	72,128	35,433	70,719
Total Assets	$2,722,086	$2,772,147	$2,719,572	$2,770,738
LIABILITIES AND EQUITY				
Current Liabilities:				
Bank overdrafts	$ 18,792	$ 16,609	$ 18,792	$ 16,609
Current portion of long-term debt and notes payable	149,379	10,848	149,379	10,848
Accounts payable	74,193	95,618	74,193	95,618
Accrued payroll	63,760	82,888	63,760	82,888
Accrued vacation	46,588	51,250	46,588	51,250
Accrued interest	30,937	15,096	21,586	11,980
Accrued restructuring	6,754	5,027	6,754	5,027
Accrued other	103,856	101,076	116,456	106,316
Due to third party payors	5,299	5,526	5,299	5,526
Total Current Liabilities	499,558	383,938	502,807	386,062
Long-term debt, net of current portion	1,281,390	1,385,950	974,913	1,218,650
Non-current deferred tax liability	59,074	82,028	59,074	82,028
Other non-current liabilities	66,650	64,905	66,650	64,905
Total Liabilities	1,906,672	1,916,821	1,603,444	1,751,645
Stockholders' Equity:				
Common stock of Holdings, $0.001 par value, 700,000,000 shares authorized, 154,519,025 shares and 145,268,190 shares issued and outstanding in 2010 and 2011, respectively	155	145	—	—
Common stock of Select, $0.01par value, 100 shares issued and outstanding	—	—	0	0
Capital in excess of par	535,628	493,828	834,894	848,844
Retained earnings	248,097	328,882	249,700	137,778
Total Select Medical Holdings Corporation and Select Medical Corporation Stockholders' Equity	783,880	822,855	1,084,594	986,622
Non-controlling interest	31,534	32,471	31,534	32,471
Total Equity	815,414	855,326	1,116,128	1,019,093
Total Liabilities and Equity	$2,722,086	$2,772,147	$2,719,572	$2,770,738

The accompanying notes are an integral part of these consolidated financial statements.

Select Medical Holdings Corporation

Consolidated Statements of Operations
(in thousands, except per share amounts)

	For the Year Ended December 31,		
	2009	2010	2011
Net operating revenues	$2,239,871	$2,390,290	$2,804,507
Costs and expenses:			
Cost of services	1,819,771	1,982,179	2,308,570
General and administrative	72,409	62,121	62,354
Bad debt expense	40,872	41,147	51,347
Depreciation and amortization	70,981	68,706	71,517
Total costs and expenses	2,004,033	2,154,153	2,493,788
Income from operations	235,838	236,137	310,719
Other income and expense:			
Gain (loss) on early retirement of debt	13,575	—	(31,018)
Equity in earnings (losses) of unconsolidated subsidiaries	—	(440)	2,923
Other income (expense)	(632)	632	—
Interest income	92	—	322
Interest expense	(132,469)	(112,337)	(99,216)
Income before income taxes	116,404	123,992	183,730
Income tax expense	37,516	41,628	70,968
Net income	78,888	82,364	112,762
Less: Net income attributable to non-controlling interests	3,606	4,720	4,916
Net income attributable to Select Medical Holdings Corporation	75,282	77,644	107,846
Less: Preferred dividends	19,537	—	—
Net income available to common stockholders and participating securities	$ 55,745	$ 77,644	$ 107,846
Income per common share:			
Basic	$ 0.61	$ 0.49	$ 0.71
Diluted	$ 0.61	$ 0.48	$ 0.71

The accompanying notes are an integral part of these consolidated financial statements.

Select Medical Corporation

Consolidated Statements of Operations
(in thousands)

	For the Year Ended December 31,		
	2009	2010	2011
Net operating revenues	$2,239,871	$2,390,290	$2,804,507
Costs and expenses:			
Cost of services	1,819,771	1,982,179	2,308,570
General and administrative	72,409	62,121	62,354
Bad debt expense	40,872	41,147	51,347
Depreciation and amortization	70,981	68,706	71,517
Total costs and expenses	2,004,033	2,154,153	2,493,788
Income from operations	235,838	236,137	310,719
Other income and expense:			
Gain (loss) on early retirement of debt	12,446	—	(20,385)
Equity in earnings (losses) of unconsolidated subsidiaries	—	(440)	2,923
Other income	3,204	632	—
Interest income	92	—	322
Interest expense	(99,543)	(84,472)	(81,232)
Income before income taxes	152,037	151,857	212,347
Income tax expense	49,987	51,380	80,984
Net income	102,050	100,477	131,363
Less: Net income attributable to non-controlling interests	3,606	4,720	4,916
Net income attributable to Select Medical Corporation	$ 98,444	$ 95,757	$ 126,447

The accompanying notes are an integral part of these consolidated financial statements.

C, Orderly Development--7(C)
TDH Inspection & Plan of Correction

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Hospital: Memphis Facility #: 422

Expanded Labor Analysis Monthly Report - Therapy

Calendar Year: 2012

PPD Breakdown	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
Patients Days	1,188.00	1,114.00	1,173.00	1,070.00	1,151.00	1,138.00	1,145.00	1,062.00	1,018.00	1,118.00	1,066.00	403.00	12,646.00
Total PT Hours PPD (2)	.42	.43	.41	.42	.42	.38	.41	.34	.28	.36	.40	.41	.39
Total OT Hours PPD (2)							.04	.22	.26	.15	.09	.10	.07
Total ST Hours PPD (2)	.13	.12	.08	.13	.12	.10	.13	.14	.13	.16	.06	.04	.11
Total RT Hours PPD (2)	2.63	2.31	2.50	2.74	2.51	2.49	2.32	2.34	2.50	2.15	2.09	2.22	2.41
Total Agency Hours PPD (3)	.24	.18	.12										.05
Total Therapy Hours PPD (1)	3.42	3.05	3.11	3.30	3.05	2.97	2.89	3.05	3.17	2.82	2.63	2.76	3.03

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Hospital: Memphis Facility #: 422

Expanded Labor Analysis Monthly Report - Nursing

Calendar Year: 2011

PPD Breakdown	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
Patients Days	1,161.00	1,079.00	1,165.00	1,128.00	1,182.00	1,099.00	1,051.00	1,078.00	1,046.00	1,012.00	1,055.00	1,141.00	13,197.00
Total RN Hours PPD (2)	4.97	4.53	4.81	5.14	4.69	4.65	4.75	4.44	4.45	4.08	4.53	4.00	4.59
Total LPN Hours PPD (2)	.53	.55	.68	.66	.53	.52	.65	.58	.53	.47	.51	.38	.55
Total CNA Hours PPD (2)	3.13	2.83	2.96	2.74	2.70	2.86	2.89	3.48	3.84	4.35	4.15	4.17	3.33
Total Agency Hours PPD (3)	.68	.67	.78	1.31	1.57	1.82	1.52	1.64	1.68	.96	.92	.57	1.17
Total Nursing Hours PPD (1)	9.30	8.57	9.24	9.85	9.49	9.85	9.81	10.14	10.50	9.86	10.11	9.13	9.64

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Hospital: Memphis Facility #: 422

Expanded Labor Analysis Monthly Report - Nursing

Calendar Year: 2012

PPD Breakdown	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
Patients Days	1,188.00	1,114.00	1,173.00	1,070.00	1,151.00	1,138.00	1,145.00	1,062.00	1,018.00	1,118.00	1,066.00	403.00	12,646.00
Total RN Hours PPD (2)	4.42	4.57	4.65	4.92	4.99	4.74	4.52	4.85	4.91	4.69	5.39	6.09	4.82
Total LPN Hours PPD (2)	.49	.40	.43	.51	.50	.45	.39	.45	.54	.58	.54	.51	.48
Total CNA Hours PPD (2)	4.11	3.36	3.97	4.40	3.99	3.96	3.61	3.88	3.96	3.89	3.86	3.91	3.91
Total Agency Hours PPD (3)	.59	1.22	1.06	.98	1.04	.81	.76	.60	.30	.08			.66
Total Nursing Hours PPD (1)	9.60	9.56	10.12	10.81	10.52	9.98	9.30	9.78	9.71	9.24	9.79	10.51	9.87

...SUCCESSOR BY ...ER TO WELLS ...D BANK MINNE... NATIONAL ASSO... ON, SOLELY IN ITS ...ITY AS TRUSTEE ...ROVIDENT BANK ... EQUITY LOAN ...BACKED CER... TES, SERIES 2000... ...er), now being the ... owner/holder of ... indebtedness, has ...quested that fore... proceedings be in... ...and said Holder ...pointed the firm ...elow as Successor ... under said Deed ... by an instrument ...corded in the afore... ...cords, to serve in ...e and stead of the ...entioned Trustee, ...of the Right to ...e was sent to the ...er by letter dated ...r 26, 2012. ...HEREFORE, said ...or Trustee, or ...ereof, pursuant to ...ed of Trust, having ...equested by the ...o to do, and by vir... ...the authority and ...ested in said Suc... Trustee by said ...Trust, will on Jan... 2013 at 1:00 p.m. at ...el and customary ... at the Shelby ...Tennessee, Court... ...ill at public outcry ...ighest bidder for ...credit upon the in... ...ess secured if the ...wner and holder ...is the successful ...r), the following... ...d property: ...RTHEAST ONE ...RACT OF THE ...GRAY AND J.C. ..., 8.65 ACRE ...IN OLD ARLING... ...E SECTION 2, ... 4, SHELBY ... TENNESSEE ...NG MORE PAR... ...LY ... DE... ... BY METES ...UNDS AS FOL...

Notice of the Right to Foreclose was sent to the Borrower by letter dated August 21, 2012.

NOW, THEREFORE, said Successor Trustee, or agent hereof, pursuant to said Deed of Trust, having been requested by the Holder so to do, and by virtue of the authority and power vested in said Successor Trustee by said Deed of Trust, will on January 02, 2013 at 1:00 p.m., at the usual and customary location at the Madison County, Tennessee, Courthouse, sell at public outcry to the highest bidder for cash (or credit upon the indebtedness secured if the lawful owner and holder thereof is the successful purchaser), the following-described property:

SITUATED IN THE 5TH CIVIL DISTRICT OF MADISON COUNTY, TENNESSEE, AND BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT A STAKE IN THE SOUTHERLY MARGIN OF LANWAY COVE AT THE NORTHEAST CORNER OF LOT NO.38 IN SECTION IV OF LANDMARK ESTATES, A PLAT OF WHICH APPEARS OF RECORD IN PLAT BOOK 3, PAGE 93, REGISTER'S OFFICE OF MADISON COUNTY, TENNESSEE; RUNS THENCE SOUTH 40 DEG. 14.9 MIN. WEST WITH THE EASTERLY MARGIN OF SAID LOT NO.38 A DISTANCE OF 123.9 FEET, MORE OR LESS, TO A STAKE; THENCE SOUTH 24 DEG. 12.5 MIN. EAST A DISTANCE OF 110 FEET TO A CONCRETE CORNER MARKER; THENCE NORTH 37 DEG. 47 MIN. EAST, WITH THE WESTERLY LINE OF SAID LOT NO.37 A DISTANCE OF 210 FEET TO

...COUNTY, TENNESSEE. BEING THE SAME PROPERTY CONVEYED TO INGLEWOOD HOMES, LLC BY WARRANTY DEED FROM MIKE MURPHY BUILDERS, LLC, A TENNESSEE LIMITED LIABILITY COMPANY, DATED 7/15/05 AND RECORDED 8/3/05 OF RECORD AT INSTRUMENT NO. 05123868, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE. BEING THE SAME PROPERTY CONVEYED TO FRANK R. PRESLEY D/B/A PRESLEY HOMES BY WARRANTY DEED FROM INGLEWOOD HOMES, LLC, DATED 2/10/06 AND RECORDED 2/20/06 OF RECORD AT INSTRUMENT NO. 06023290, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE. BEING THE SAME PROPERTY CONVEYED TO RAY MADISON AND TAMEKA MADISON, MARRIED BY WARRANTY DEED FROM FRANK R. PRESLEY D/B/A PRESLEY HOMES, DATED 11/29/06 AND RECORDED 12.5.06 OF RECORD AT INSTRUMENT NO.06177117, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE.

For informational purposes only, this property is commonly known as 4465 Whisperwood Drive, Collierville, TN 38017, Parcel ID C0258Z C00042.

The property shall be free from all right and equity of redemption, statutory or otherwise, homestead, dower, courtesy, elective share, and all other exemptions that are expressly waived in said Deed of Trust, and the title is believed to be good, but the Successor Trustee will sell and convey only as Successor Trustee, "as is" and "where is" and without covenants of seizing or warranties of title.

Listing of Subordinate Lienholders: N/A

Listing of Other Interested Parties: N/A

This sale is subject to items: easements; encumbrances; property taxes; rights of redemption of taxing entities; all matters shown on any recorded plat(s) or plat(s); any unpaid taxes; any restrictive covenants, easements or setback lines that may be applicable; any statutory rights of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; any matter that an accurate survey of the premises might disclose; and other matters which are prior in right to the lien of the aforesaid Deed of Trust.

If a high bidder fails to close a sale, the Successor Trustee shall have the option of making the sale to the next highest bidder. The sale held pursuant to this Notice may be rescinded at the Successor Trustee's option at any time. The right is reserved to adjourn the sale to another day, time and/or place certain without further publication, upon announcement at the time and place for the sale set forth above, or at any date and time fixed by a preceding postponement. Alternatively, at its option, Successor Trustee may

Successor Trustee may give a new notice of sale.

Weissman Nowack Curry & Wilco, PC

One Alliance Center, 4th

File #: 01...

NOTIFICATION OF INTENT TO APPLY FOR A Certificate of Need

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that Spinal Health Care Associates, P.C. ("Applicant"), 8132 Cordova Road, Suite 101, Cordova, TN 38106, owned by Rick Woods, D.C., 8132 Cordova Road, Suite 102, Cordova, TN 38106, and managed by itself, intends to file an application for a Certificate of Need for establishment of a specialty ambulatory surgical treatment center ("ASTC") providing only manipulation under anesthesia ("MUA") services. This new ASTC will be located in an existing building, and will have one (1) procedure room, one (1) exam room, one (1) recovery room, along with other related space. This Applicant will provide only MUA and related services, which are minimal surgical procedures and no operative surgical procedures will be performed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that the specialty ASTC will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $474,667, which includes the cost of the filing fee.

The anticipated date of filing the application is: December 14, 2012.

The contact person for this project is: E. Graham Boles, Jr., Attorney who may be reached at 5401 Kingston Pike, Suite 300, Knoxville, TN 37919, 865/310-3200.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

...Instrument 0004823, Register's Office for Madison County, Tennessee, from ...ing the present owner/holder of said indebtedness, has now re...

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Select Specialty Hospital-Memphis (a long term acute care hospital, owned and managed by Select Specialty Hospital-Memphis, Inc. (a corporation), intends to file an application for a Certificate of Need to add twenty-eight (28) long term acute care beds to its facility located in leased space at St. Francis Hospital, 5959 Park Avenue, Memphis, TN 38119. The project cost as CON purposes is estimated at $6,930,000. This project contains no major medical equipment and does not add or discontinue any core health service.

Select Specialty Hospital is currently licensed by the Board for Licensing Healthcare Facilities (TN Department of Public Health) for forty-nine (49) long term acute care beds. Select Specialty has received State approval for licensure of ten (10) additional long term acute care beds without CON review, under a statutory exemption available to hospitals of fewer than 100 beds. Upon its implementation, Select will be licensed for forty-nine (49) long term acute care beds, so that the twenty-eight (28) bed expansion proposed in this Certificate of Need application would increase the Select license to seventy-seven (77) long term acute care beds. St. Francis Hospital, which is leasing these beds to Select, will reduce its current 819-bed general hospital license by 10 beds to reflect the approved 10-bed expansion of Select through the CON exemption process, and will reduce its license by 28 more beds if this CON application is approved. The net effect of these changes will be that the project will not change the service area's total licensed complement of general acute care plus long term acute care hospital beds.

The anticipated date of filing the application is on or before December 14, 2012. The contact person for this project is John Watkins, who may be reached at Development Support Group, 4214 Hillsboro Road, Suite 209, Nashville, TN 37215, (615) 665-1018.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency, Andrew Jackson Building,
500 Deaderick Street, Suite 850, Nashville, Tennessee 37243

Pursuant to TCA Sec. 68-11-1607(c)(1), (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

...just landed a spot o...

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AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 14 day of December (Month), 2012 (Year) a Notary

Public in and for the County/State of Davidson / Tennessee.

NOTARY PUBLIC

My commission expires August 16 (Month/Day), 2016 (Year).

BEVIN M. SHELLENBERGER
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY

My Commission Expires August 6, 2016

Copy

Supplemental #1

Select Specialty Hospital - Memphis

CN1212-062

DSG Development Support Group

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

2012 DEC 21 PM 12 20

December 20, 2012

Mark Farber, Assistant Executive Director
Health Services and Development Agency
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: Certificate of Need Application CN1212-062
Select Specialty Hospital-Memphis, Inc.

Dear Mr. Farber:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section A, Applicant Profile, Item 6**
Please submit a fully executed First Amendment to the Lease Agreement or an Option to Lease that indicates that the First Amendment to the Lease Agreement will be executed upon approval of this application.

The applicant anticipates that an option to lease the additional floor will be fully executed by the parties this week, and will be submitted under separate cover, immediately thereafter.

2. **Section A, Applicant Profile, Item 13**
a. Does the applicant anticipate establishing a contract with United Healthcare Community Plan?
b. Why did TennCare Select deny a contract request?

The application was in error with respect to these plans. Attached is a revised page 4R. The applicant is in fact contracted with both TennCare Select and with BlueCare (the largest enrollment in the area).

On August 29, 2012, United's representative emailed Select Specialty that United preferred to negotiate on a case-by-case basis, rather than to have a contract. Select therefore has no reason to apply for a contract so soon after this decision.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

3. Section B, Project Description, Item I.
Please describe the conditions that are typical for defining a long-term acute patient and the typical treatments and services provided to these patients.

LTACHS care for extremely ill patients who have been stabilized in a general acute care hospital, but remain too ill to be transferred to acute rehabilitation, skilled nursing, or home care. Most are elderly. They are medically fragile or unstable. They typically require acute care of several weeks' duration beyond what a short-term acute care hospital can afford to provide, with limited reimbursement from Medicare and commercial payors. Medicare has created this "second stage" environment especially for such patients, providing reimbursement for extended care beyond what a short-term hospital's DRG is designed to pay for. Typical lengths of stay in an LTACH exceed 25 days.

Typical conditions suitable for admission to LTACH include chronic respiratory disorders and other pulmonary conditions; cardiac, neurological, and renal conditions; infections and severe wounds. Many are medically complex cases, with a combination of issues that often require cardiac monitoring, long term antibiotic and nutritional therapies, pain control, and continued life support. One of Select Specialty Memphis's special strengths is its acceptance of ventilator-dependent patients, and their successful weaning from the ventilator. Programs of care are provided for patients with serious conditions such as multiple nervous system disorders, cardiovascular disorders, extended antibiotic therapy, patients with tracheotomies, ventilators, dialysis, TPN, burn care, oncological complications, dopamine for renal infusion, and numerous other post-surgical and complex medical conditions.

Services required for these patients include acute care nursing (5-8 hours per day), therapies (PT, OT, RT, Speech), diagnostic laboratory and imaging tests, surgery, nutritional control, and any type of service provided in the typical acute care setting. In this and other LTACH's, however, as indicated in the application, the host hospital contracts to provide many of these services within the LTACH itself, or downstairs in the hospital departments (surgery, imaging, etc.).

4. Section B, Project Description, Item II.A.
Please provide documentation from CMS that verifies the end of the LTACH bed moratorium at the end of 2012.

Please see the memorandum from CMS following this page. It is dated July 23, 2010. It notes that the Affordable Care Act extended the ending date of the moratorium until December 28, 2012.

Also, please see similar additional CMS materials at the back of this supplemental submission.

For more specific and detailed reference:

a. The Medicare, Medicaid, and SCHIP Extension Act of 2007 prohibited the establishment and classification of new LTACHs or satellites during the three calendar years (2008-2010) commencing on December 29, 2007.

b. The Patient Protection and Affordable Care Act subsequently extended this moratorium for an additional two years to December 28, 2012.

c. The Centers for Medicare & Medicaid Services applied the moratorium in its regulations at 42 CFR 412.23(e)(6), which states that "for the period beginning December 29, 2007 and ending December 28, 2012, a moratorium applies to the establishment and classification of a long-term care hospital or long-term care hospital satellite facility."

d. In a memorandum to State Survey Agency Directors, CMS specifically noted that "the Affordable Care Act extended the ending date of the moratorium from December 28, 2010 to December 28, 2012".

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C-10-25-Hospitals

DATE: July 23, 2010

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Extension of Long-Term Care Hospital (LTCH) Moratorium

Memorandum Summary

- **LTCH Moratorium Extended:** A statutory moratorium prevents, with certain exceptions, the establishment of new LTCHs, an increase in existing LTCHs' number of certified beds, or the establishment of a satellite by an existing LTCH. The Affordable Care Act extended the ending date of the moratorium from December 28, 2010 to December 28, 2012.
- **No Changes to Administration of Moratorium:** The rules and policy for administering the moratorium, including the exceptions, the criteria for granting exceptions, and the methods to evaluate requests for exceptions, are not altered. Regional Offices must to rely upon the guidance in S&C-08-26, as updated by S&C-09-32.

Hospitals seeking to be excluded from the Medicare Hospital Inpatient Prospective Payment System for the first time as an LTCH must have a provider agreement with Medicare and must have an average Medicare inpatient length of stay (LOS) greater than 25 days, as provided under the existing regulations at 42 CFR 412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Social Security Act,. The Medicare Administrative Contractor (MAC) or legacy Fiscal Intermediary (FI), as applicable, verifies whether the hospital meets the average LOS requirement.

Section 114(d) of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) (Pub. L. 110-173), enacted December 29, 2007, established a three-year moratorium on the designation of new LTCHs or LTCH satellites, and on an increase of beds in an LTCH. The moratorium began on December 29, 2007 and was originally scheduled to end on December 28, 2010. However, Section 3106(a) of the "Affordable Care Act" (ACA) extended the ending date of the moratorium by two years. Therefore, the LTCH moratorium is now scheduled to end December 28, 2012. The LTCH moratorium regulation at §42 CFR 412.23(e)(6) will be updated to reflect that revision in the law.

S&C-08-26, issued June 13, 2008 and S&C-09-32, issued on April 17, 2009 provided detailed guidance on the process Centers for Medicare & Medicaid Services (CMS) Regional Offices and MACs/legacy fiscal intermediaries must use for evaluating applications for an exception to the moratorium under Section 114(d) of MMSEA. With the exception of the change in the moratorium end date, this guidance continues in effect. Copies of these memoranda are attached for your convenience.

Questions: If you have questions about the LTCH moratorium exception requirements, please contact Judith Richter via e-mail at Judith.richter@cms.hhs.gov. Survey and Certification operational questions should be directed to David Eddinger via e-mail at david.eddinger@cms.hhs.gov.

Effective Date: This guidance is effective immediately. Please ensure that all certification personnel are appropriately informed as to using this guidance within 30 days of this memorandum.

Training: The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators.

/s/
Thomas E. Hamilton

Attachments:

1. Expansion of Moratorium Exception on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds
2. Moratorium on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds

cc: Survey and Certification Regional Office Management

Section B, Project Description, Item II.C.

a. Please provide the applicant referral source mix (locations from where patients are referred). What percentage of the applicant's patients are referred from St. Francis Hospital? Will this change after project completion? Is the applicant currently complying with the 25% threshold limit pertaining to referrals from the host hospital? If the applicant is receiving more than 25% of its referrals from St. Francis, please discuss the impact and ramifications of this situation.

The referenced rule applies to Medicare admissions, not total admissions. Once called the "25% Rule", it has evolved somewhat.

Currently, no more than 50% of Select's total Medicare admissions can come from St. Francis, its host hospital, through 11-30-13. From 12-1-13 onward, that limit will be reduced to 25%, which is also the limit with respect to other admissions sources--except for the Baptist and Methodist systems.

Admissions from Baptist and Methodist can be up to 27.41% and 35.35% respectively, because both systems have a Medicare designation as a "market-dominant" provider to Medicare in their region. (Percentages apply to each licensed hospital or hospitals sharing a common provider number.)

During CY2012, approximately 20.2% of Select Specialty Hospital's Medicare admissions have been referred from St. Francis Hospital. In CY2011, this percentage was 20.5%. So Select is in compliance with the referral limitation rules of Medicare.

These percentages from St. Francis are not projected to change significantly after project completion. Select has always been, and will continue to be, in compliance with Medicare limitations on host hospital referrals.

Following this page are new historical and projection tables showing total and Medicare admissions from source hospitals. Select currently has no admissions from sources other than hospitals. In future years, between 1% and 2% of new admissions from patients' homes are anticipated by management.

SUPPLEMENTAL TABLE–HISTORICAL & PROJECTED ADMISSIONS TO SELECT SPECIALTY HOSPITAL-MEMPHIS BY REFERRAL SOURCE

1. LTACH Admissions to Select Specialty-Memphis ALL PAYOR CLASSES by Referral Source-Historical and Projected

Facility/Year	2009	2010	2011	2012	2014	2015	2016	2017
St. Francis Hospital	143	123	90	104	150	162	172	186
St. Francis-Bartlett	49	42	27	46	60	65	70	72
Baptist Mem. Hospitals	52	51	45	45	55	58	62	66
Methodist Healthcare Hospitals	116	116	103	139	151	158	165	170
The MED	45	27	40	29	29	31	32	32
Surrounding County Hospitals	59	67	113	98	225	271	333	351
Service Area Nursing Homes								
Patient Homes				5	7	8	9	10
Other Referral Sources								
TOTALS	464	426	418	466	677	753	843	887

2. LTACH Admissions to Select Specialty-Memphis MEDICARE ONLY by Referral Source-Historical and Projected

Facility/Year	2009	2010	2011	2012	2014	2015	2016	2017
St. Francis Hospital	103	83	60	63	95	105	112	124
St. Francis-Bartlett	28	25	23	34	47	50	53	55
Baptist Mem. Hospitals	43	37	31	34	45	48	52	55
Methodist Healthcare Hospitals	72	60	67	87	98	105	112	116
The MED	29	12	20	17	17	18	19	20
Surrounding County Hospitals	48	45	92	73	167	196	236	245
Service Area Nursing Homes								
Patient Homes				4	5	5	6	6
Other Referral Sources								
TOTALS	323	262	293	312	474	527	590	621

3. LTACH Admissions to Select Specialty-Memphis PERCENT OF MEDICARE ADMISSIONS BY SOURCE by Referral Source-Historical and Projected

Facility/Year	2009	2010	2011	2012	2014	2015	2016	2017
St. Francis Hospital	31.9%	31.7%	20.5%	20.2%	20.0%	19.9%	19.0%	20.0%
St. Francis-Bartlett	8.7%	9.5%	7.8%	10.9%	9.9%	9.5%	9.0%	8.9%
Baptist Mem. Hospitals	13.3%	14.1%	10.6%	10.9%	9.5%	9.1%	8.8%	8.9%
Methodist Healthcare Hospitals	22.3%	22.9%	22.9%	27.9%	20.7%	19.9%	19.0%	18.7%
The MED	9.0%	4.6%	6.8%	5.4%	3.6%	3.4%	3.2%	3.2%
Surrounding County Hospitals	14.9%	17.2%	31.4%	23.4%	35.2%	37.2%	40.0%	39.5%
Service Area Nursing Homes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Patient Homes	0.0%	0.0%	0.0%	1.3%	1.1%	0.9%	1.0%	1.0%
Other Referral Sources	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTALS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Hospital records.

b. Please complete the following chart:

LTACH Total Admissions to Select Specialty-Memphis
(by Referral Source-Historical and Projected

Facility/Year	2011	2012	2014	2015	2016	2017
St. Francis Hospital						
St. Francis-Bartlett						
Baptist Mem. Hospitals (2)						
Methodist Hospitals (4)						
The MED						
Surrounding County Hospitals						
Service Area Nursing Homes						
Patient Homes						
Other Referral Sources						

Please see the tables on the preceding pages, which supply this information and much more.

SUPPLEMENTAL- # 1
December 21, 2012
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6. **Section B, Item III.A.**
What is the size of the site in acres?

The site of St. Francis Hospital is approximately 42 acres. Following this page is an amended site map showing that acreage.

7. **Section B, Item III.B1.**
Should the source for the distance tables read "Google Maps, Dec. 2012" instead of "2013"?

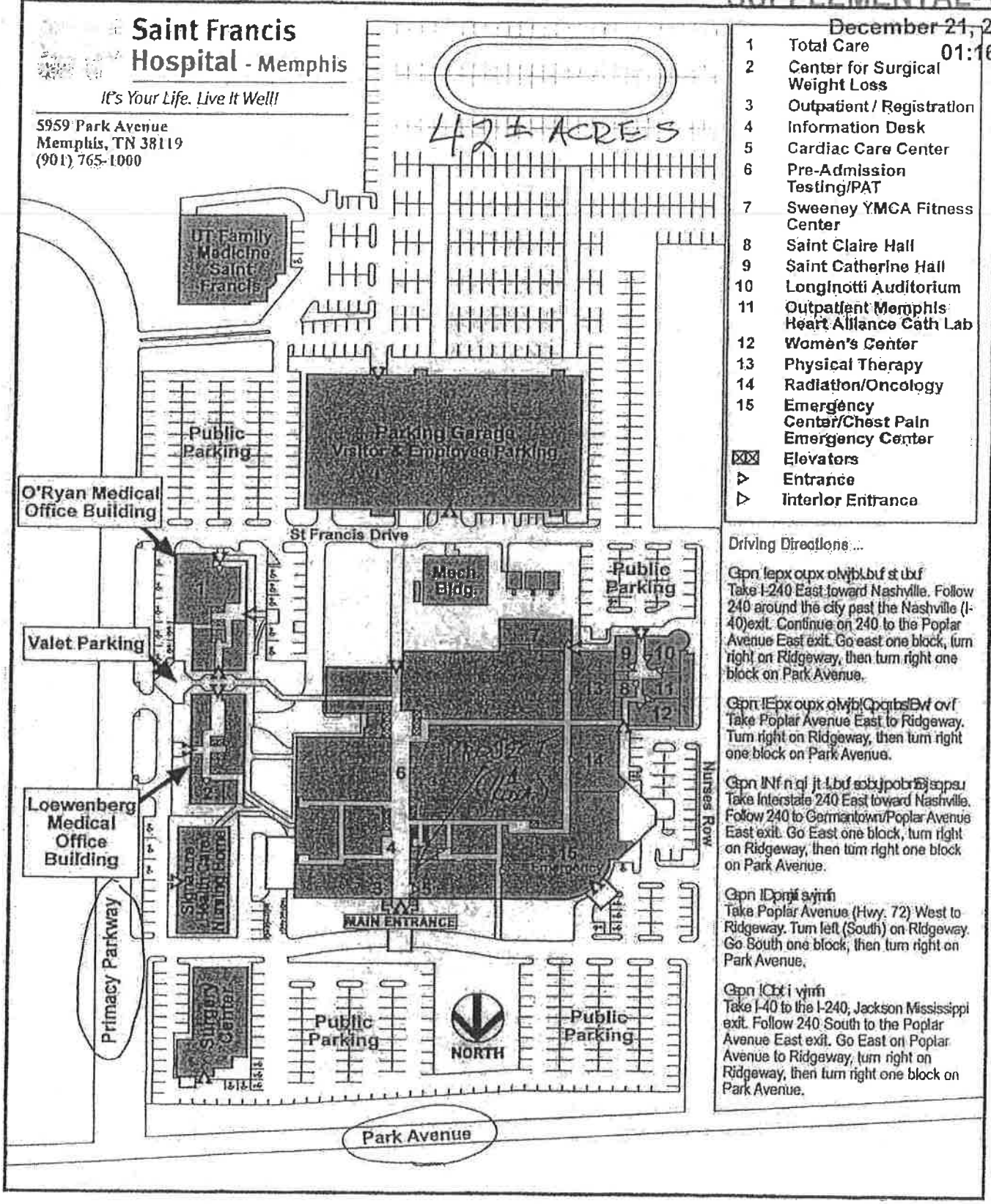
Yes, it should. Thank you. Attached after this page, following the site map, is a revised page 16R with the source footnote's date corrected on both tables.

8. **Section C, Need, Item 1.a. (Long Term Care Hospital Beds-B. Economic Feasibility 1.)**
Please provide the same information for all general acute care hospitals in Shelby County.

Attached after this page, following page 16R, is a revised page 22R with charge data from all Shelby County's general acute care hospitals added to Table Nine. With it is revised page 56R, Table Twenty-Two, with the same data.

9. **Section C, Need, Item 3.**
On page 34, second paragraph, did you mean to state "Only three of the twenty-one counties in this project's declared 43-county service area have shorter drive times to Memphis than to Nashville"?

No; and again thanks. It should read "... shorter drive times *to Nashville than to Memphis*." Attached after this page, following page 56R, is revised page 34R with that phrase corrected. Almost all service area counties are closer to this project than to Nashville LTACH's.



10. Section C, Need, Item 6

a. The methodology for projecting increased utilization is noted; however is the total growth to Year 2017 realistic where patient days are expecting to increase by 90% between 2012 and 2017?

Select fully expects to double its admissions and patient days over the next five years. This is not unrealistic considering that we are dealing with small numbers. For example, the projections for CY2016, when Select will reach 85% occupancy, require only another 31 to 32 admissions per month over current levels.

This will be achieved in two ways--by working with medical staffs and administrations at current referral hospitals to increase the number of patients they refer to LTACH care; and by working with other hospitals in the region to become referral sources.

Review of Federal MEDPAR discharge data and personal meetings with management at both Jackson-Madison General Hospital (Jackson, TN) and North Mississippi Medical Center (Tupelo)--which are established referral sources for Select--have convinced Select that those two facilities can, and will, significantly increase their discharges to LTACH care.

And ten other hospitals in the region have been targeted as potential new referral sources for Select, once more beds become available in Memphis. Select will be a destination for many new referrals because of its reputation. Select offers special care programs of great interest--such as its unusually high success rates in weaning ventilator-dependent patients off their vents--a program developed by working with specialists at Duke Medical School.

It would be an error to regard the level utilization at the Memphis facilities the past four years as indication that no more demand exists. That would only be true if the LTACH's were not full. The fact is that this group of LTACH's have been at full occupancy for years, while turning away admissions. Their admissions have been level only from a lack of beds, caused by a Medicare moratorium that Medicare needed to develop more funding resources for this type of care.

b. Is it also realistic to expect that this much of an increase in bed capacity will not have a significant impact on existing LTACH providers. The recently approved relocation of 24 LTACH beds to The MED will likely result in The Med reducing its current referral of LTACH patients to existing operating providers.

Select does not anticipate that the MED will reduce its current referrals to existing LTACHs. The MED is going to open only 24 LTACH beds. Its CON application documented that the MED has enough qualified patients to fill 78 LTACH beds--54 more than the 24 beds they have just been approved to move to their campus. The MED also said that most of these patients are not now going to LTACH. So it is not clear that the MED's new beds will be filled at the expense of Methodist, Baptist, and Select referrals from the MED.

As for the other providers, Select believes that the majority of its additional admissions will come from hospitals outside Shelby County, for which Select is a closer provider than other LTACH's in other cities. This is based on discussions during site visits and on potential new referrals from smaller hospitals in the region that do not now discharge many patients to Memphis LTACHs.

There does not seem to be a reliable planning formula that can answer the question of how much additional LTACH bed need exists. The Guidelines formula of 0.5 beds per 10,000 service area population is possibly 15 years old. The population has aged since it was deemed appropriate. Aging increases the demand for LTACH services, because 80% of LTACH patients are of Medicare age. The 167 total LTACH beds that Memphis would have if this application is approved would give the service area only 0.7 beds per 10,000 population. It is hard to develop a bed need formula that is precise. And it should be remembered that this project does not construct any new bed spaces at all. It is just a productive use for existing beds that are now vacant.

a. Current approved LTACH beds = 139*
b. LTACH Beds if this CON application is approved = 167
c. CY2015 service area population = 2,433,814
d. 0.5 beds / 10,000 population = projection of 122 bed total need, Yr 2
e. 0.7 beds / 10,000 population = projection of 170 bed total need, Yr 2

* *39 existing+10 approved at Select; 24 approved at MED; 36 existing at Methodist; 30 existing at Baptist*

11. **Section C. Economic Feasibility Item 1 (Project Cost Chart)**
The submission of the letter supporting the construction cost estimate being submitted under separate cover is noted.

The contractor's letter attesting to the adequacy of the estimate is provided following this page. Also provided is the Cost PSF chart for Attachment B.II.A.

12. **Section C, Economic Feasibility, Item 10.**
Which entity will actually be funding this project, Select Specialty-Memphis or its parent Select Medical Corporation? Document where in the financial statements provided are the funds for the proposed project.

Select Specialty-Memphis will fund the project. In Attachment C, Economic Feasibility--10, there is a CY2012 (Jan-Oct) balance sheet for the hospital. Below the "Current Assets" section is a separate section named "Affiliates". In Affiliates, the line item entitled "Advances To" denotes an amount of cash that is held at Select Medical Corporation (the parent) on behalf of Select-Memphis (the hospital). In CY2012 (Jan-Oct) that amount was $14,814,576 (rounded). There is a similarly large fund in the CY2011 balance sheet.

Select-Memphis has access to that amount in the form of cash, to cover the project cost. This will not be treated as a loan from corporate; the hospital will not be charged interest on it. In practical terms, it is like a hospital savings account held at the parent company to earn interest. It is funded from prior years' earnings by this hospital, and held for its needs.

BRASFIELD & GORRIE
GENERAL CONTRACTORS

December 20, 2012

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
161 Rosa Parks Boulevard
Nashville, TN 37203

RE: Select Specialty Hospital Memphis
Renovation of 11th Floor Nursing Unit – LTACH Beds

Dear Mrs. Hill:

We have reviewed Select Medical Corporation's construction cost estimate of $2,059,315 for renovation of a 21,677 SF nursing floor at Saint Francis Hospital, for additional LTACH beds. Based on discussions with Select's design and construction staff, and on our experience with similar projects, and on our knowledge of the current healthcare market, it is our opinion that this construction cost estimate is reasonable and sufficient to accomplish the proposed renovation.

Below is a summary of the current building codes that would apply to the project. This may not be totally inclusive, but it expresses Select's intent to address all applicable codes and standards, whether local, State, or Federal, in the design and construction of this project. The undersigned is a licensed contractor in the State of Tennessee.

- Guidelines for the Design and Construction of Health Care Facilities (current)
- Rules of the Tennessee Board for Licensing of Healthcare Facilities
- Standard Building Code
- National Electrical Code
- NFPA (National Fire Protection Code)
- ADA (Americans with Disabilities Act)

Sincerely,

Brasfield & Gorrie
Michael J. Dunn, Senior Project Manager
State of Tennessee ID # 00027321 Expiration date: 05/31/2013

cc: Dan Blaker, Select Medical Corporation
Todd Jackson, Brasfield & Gorrie

BRASFIELD AND GORRIE, LLC
3021 7th Avenue South Birmingham, Alabama 35233
P: 205.328.4000 F: 205.251.1304 W: BrasfieldGorrie.com

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Eleventh Floor										
Saint Francis Hospital										
38 Patient Rooms		7600 SF			7600 SF	0	7600 SF	$141.00	na	$1,071,600.00
Support Areas		14,077 SF			14,077 SF	0	14, 077 SF	$70.17	na	$987,715.00
B. Unit/Depart. GSF Sub-Total										
C. Mechanical/ Electrical GSF										
D. Circulation /Structure GSF										
E. Total GSF		21,677 SF			21,677 SF		21,677 SF	$95.00	$0	$2,059,315.00

13. **Section C, Economic Feasibility, Item 11.**

Has the applicant considered the alternative of delaying this project to evaluate the utilization of the recently added ten beds allowed by the "under 100 hospital bed" exemption and then adding additional ten bed increments if needed utilizing the exemption in the future.

Yes, but as stated on page 12 of the application, Select is offering to lease, license and renovate the entire floor at one time, prior to moving even the first ten patients onto it, in order to avoid subjecting patients on that floor to annual phased construction on that floor over the next four years. There are serious issues involved in construction in or near occupied nursing units. Phasing would make the project more costly and would increase patient risks from noise, infection issues, dust, etc.

Select believes that the better course of action is for the HSDA to approve Select's licensure of the remaining 28 beds on this floor, so that the entire floor can be renovated before moving any patients onto it. This would result in 28 more beds being licensed in 2014. The phased approach would result in the very same licensure by 2016--but at greater cost, and greater risk, from almost continuous construction proceeding in the midst of patient care.

14. **Section C, Orderly Development, Item 3.**
Table Twenty-Four is blank. Please complete the table.

Revised page 62R with Table Twenty-Four completed is attached following this page.

15. **Section C, Orderly Development, Item 7.**
Survey findings and Joint Commission findings for Parkridge Medical Center were submitted. Please provide the information for Select Specialty Hospital-Memphis.

Attached at the end of this supplemental response (due to its length) is the required information for this applicant.

16. **Affidavit**
A signed and notarized affidavit must be submitted with each filing of an application and supplemental information. An affidavit was not included with this application. Please submit a completed affidavit for the original application and one for the supplemental information. Please note there is an affidavit form for the original filing and a separate form for supplemental responses.

Please look between the submittal cover letter and the title page of the application. The affidavit is at that location in our photocopy of the December 14 filing. If you do not find it there, please accept the copy attached after this page.

Following this page there are two additional items. First is a revised Table Sixteen (Demography of the Service Area), with the latest 2010 Census median age data for the Tennessee primary service area counties. Second is a revised page 24R, that fills in a Table number that was previously omitted from the narrative.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

Table Sixteen: Demographic Characteristics of TN Primary Service Area Counties (Supplemental) Of Select Specialty Hospital-Memphis 2013-2017

Demographic	SHELBY	DYER	FAYETTE	GIBSON	LAUDERDALE	MADISON	McNAIRY	TIPTON	PRIMARY SERVICE AREA	STATE OF TENNESSEE
Median Age-2010 US Census	34.6	39.3	41.9	39.9	36.4	36.8	41.6	36.6	NA	38.0
Total Population-2013	956,126	39,238	39,818	49,303	28,641	101,634	26,476	63,857	1,305,093	6,361,070
Total Population-2017	983,298	40,042	41,841	49,878	29,626	104,914	26,908	67,365	1,343,872	6,575,165
Total Population-% Change 2013 to 2017	2.8%	2.0%	5.1%	1.2%	3.4%	3.2%	1.6%	5.5%	3.0%	3.4%
Age 65+ Population-2013	103,296	5,910	5,968	8,634	3,937	13,277	4,910	7,541	153,465	878,496
% of Total Population	10.8%	15.1%	15.0%	17.5%	13.7%	13.1%	18.5%	11.8%	11.8%	13.8%
Age 65+ Population-2017	118,044	6,515	7,093	9,081	4,442	15,013	5,290	8,748	174,226	987,074
% of Population	12.0%	16.3%	17.0%	18.2%	15.0%	14.3%	19.7%	13.0%	13.0%	15.0%
Age 65+ Population-% Change 2013-2017	14.3%	10.2%	19.0%	5.2%	12.8%	13.1%	7.7%	16.0%	13.5%	12.4%
Median Household Income	$46,102	$38,909	$57,437	$37,577	$34,078	$40,667	$34,953	$50,869	$42,574	$43,314
TennCare Enrollees (08/12)	231,988	9,467	5,686	11,115	7,326	21,161	7,017	11,615	305,375	1,211,113
Percent of 2012 Population Enrolled in TennCare	24.3%	24.1%	14.3%	22.5%	25.6%	20.8%	26.5%	18.2%	23.4%	19.0%
Persons Below Poverty Level (2012)	192,181	7,534	4,659	8,825	7,246	19,514	5,957	9,770	255,686	1,049,577
Persons Below Poverty Level As % of Population (US Census)	20.1%	19.2%	11.7%	17.9%	25.3%	19.2%	22.5%	15.3%	18.9%	16.5%

Sources: TDH Population Projections, Feb. 2008; U.S. Census;
TennCare Bureau. PSA data is unweighted average or total of county data.
NR means not reported in U.S. Census source document.

The Joint Commission

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

May 27, 2010

Jeffery Denney
COO
Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Joint Commission ID #: 148160
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 05/27/2010

Dear Mr. Denney:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning February 19, 2010. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

June 29, 2009

Salvatore M. Iweimrin
COO
Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Joint Commission ID #: 148160
Program: Laboratory Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 06/29/2009

Dear Mr. Iweimrin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing

This accreditation cycle is effective beginning April 16, 2009. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 25 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

The following laboratory services have been surveyed under Joint Commission standards in accordance with the Clinical Laboratory Improvement Amendments of 1988 :

CLIA# 44D0927731 for the specialties and subspecialties of Routine Chemistry.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission

Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160

Evidence of Standards Compliance (60 Day) Submitted: 6/29/2009

Program(s)
Laboratory Accreditation

Executive Summary

Laboratory Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

SUPPLEMENTAL- # 1

December 21, 2012
01:16pm

The Joint Commission
Summary of Compliance

Program	Standard	Level of Compliance
LAB	IM.6.180	Compliant
LAB	QC.1.73	Compliant
LAB	QC.1.75	Compliant
LAB	QC.5.10	Compliant
LAB	QC.6.30	Compliant

3138-01818

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission

April 23, 2009

Salvatore M. Iweimrin
COO
Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Joint Commission ID #: 148160
Program: Laboratory Accreditation
Accreditation Activity: Unannounced Full Event
Accreditation Activity Completed: 04/15/2009

Dear Mr. Iweimrin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission

Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160

Program(s)
Laboratory Accreditation Program

Surveyor(s) and Survey Date(s)
Nancy J. Cacciatore-Huber, MT - (04/15 - 04/15/2009)

Executive Summary

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Findings

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

DIRECT Impact Standards:

Program:	Laboratory Accreditation Program	
Standards:	NPSG.01.01.01	EP3

INDIRECT Impact Standards:

Program:	Laboratory Accreditation Program	
Standards:	IM.6.160	EP1
	QC.1.73	EP3
	QC.1.75	EP3
	QC.5.10	EP4
	QC.6.30	EP5

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

Select Specialty Hospital

FAX COVER SHEET

TO: Stephanie M. **FROM:** Jeff Denny

TO FAX: **FROM FAX:**

DATE: 717-635-3138

CC: **SUBJECT:** Surveys

NUMBER OF PAGES (INCLUDING COVER):

MESSAGE:

Called Question.

JD

Notice of Confidentiality

"The information contained in this fax transmission is intended only for the individual(s) named above. Such information is confidential and may be legally privileged. If you have received this fax transmission in error, please notify me immediately by using the telephone number set forth below so that I may arrange for this fax transmission to be returned to me or destroyed. If the recipient of this fax transmission is not the individual(s) named above, such recipient is hereby notified that this fax transmission may not be copied, disseminated, distributed or otherwise disclosed to others."

3138 - 08562

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission

Select Specialty Hospital - Memphis
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160

Date(s) of Survey: 2/21/2007 - 2/23/2007

PROGRAM(S)
Hospital Accreditation Program

SURVEYOR(S)
Bonnie L. Briggle, MHA, RN

Executive Summary

As a result of the accreditation activity conducted on the above date, your organization must submit Evidence of Standards Compliance (ESC) within 45 days from the day this report is posted to your organization's extranet site. If your organization does not make sufficient progress in the area(s) noted below, your accreditation may be negatively affected.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

717-635-3138

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Assessment and Care/Services

Standard: PC.11.40

Program: HAP

Standard Text: Any use of restraint (to which these standards apply) is initiated pursuant to either an individual order (standard PC.11.50) or an approved protocol (standard PC.11.60), the use of which is authorized by an individual order.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
1. Restraint (except for restraint initiated under a protocol as described in standard PC.11.60) is used upon the order of a licensed independent practitioner.*
* This standard is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care staff (that is, physician assistants and nurse practitioners) to the extent recognized under state law or a state's regulatory mechanism. In the states that allow this delegation, hospitals that permit these individuals to order restraint for medical or surgical reasons are considered to be in compliance with this standard.

Surveyor Findings

EP 1
Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
No physician order was written for restraints for two days as required by hospital policy and regulation.

Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
No physician order was written for restraints for four days as required by hospital policy and regulation.

The Joint Commission
Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Quality Improvement Expertise/Activities

Standard: Requirement 2C

Program: HAP

Standard Text: Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

Secondary Priority Focus Area(s): Patient Safety

Element(s) of Performance

Scoring Category : A
4. The organization collects data on the timeliness of reporting critical results/values.

Surveyor Findings

EP 4
Observed in the Data System Tracer at Select Specialty Hospital -Memphis site.
The organization has not been able to collect data on the timeliness of reporting critical results/values due to inconsistent documentation by staff. A process had been recently been implemented to capture the data for analysis.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Life Safety Code

Inpatient Occupancy Existing Healthcare Occupancies; Section V - Exits

Requirement: EC.A.5K.1

Phrase: Existing Health Care Occupancies Exit signs are: readily visible from any direction of access. (EC.A.5K)(EC.A.5K.1)

Surveyor Findings:

At the end of both corridors in the unit, there was only one readily visible exit sign rather than the required two exit signs.

The Joint Commission
Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Assessment and Care/Services

Standard: PC.11.100

Program: HAP

Standard Text: Each episode of restraint use is documented in the patient's medical record, consistent with hospital policies and procedures.

Secondary Priority Focus Area(s) Information Management

Element(s) of Performance

Scoring Category : C
2. Documentation includes the following:

Relevant orders for use
Results of patient monitoring
Reassessment
Significant changes in the patient's condition

Surveyor Findings

EP 2
Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
Documentation of the monitoring of the patient in restraints was not complete for four days as required by hospital policy.

Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
In a second patient tracer, documentation of the monitoring of the patient in restraints was not complete for three days as required by hospital policy.

The Joint Commission

Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Organizational Structure

Standard: HR.2.10

Program: HAP

Standard Text: The hospital provides initial orientation.

Secondary Priority Focus Area(s) Orientation & Training

Element(s) of Performance

Scoring Category : B
1. The hospital determines what key elements of orientation should occur before staff provide care, treatment, and services.

Surveyor Findings

EP 1
Observed in the Competency Assessment System Tracer at Select Specialty Hospital -Memphis site. The organization has not determined the key elements of orientation that should occur before the contract dialysis and housekeeping staff provide care, treatment and services.

Standard: IM.1.10

Program: HAP

Standard Text: The hospital plans and designs information management processes to meet internal and external information needs.

Secondary Priority Focus Area(s) Information Management

Element(s) of Performance

Scoring Category : B
1. The hospital bases its information management processes on an assessment of internal and external information needs.

The assessment identifies the flow of information throughout a hospital, including information storage and feedback mechanisms.
The assessment identifies the data and information needed: within and among departments, services, or programs; within and among the staff, the administration, and the governance for supporting relationships with outside services and contractors; with licensing, accrediting, and regulatory bodies; with purchasers, payers, and employers; for supporting informational needs between the hospital and the patients; and for participating in research and databases.

Surveyor Findings

EP 1
Observed in the Pharmacy Department at Select Specialty Hospital -Memphis site.
Access to the automated medication dispensing machine at the organization was evaluated by reviewing the most recent three nursing terminations. One of the three nurses continued to have access one week after termination. The Human Resources staff was responsible to notify the Pharmacy Director of terminations. The Human Resources staff member was a new employee and this process had not been addressed in orientation.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Patient Safety

Standard: EC.6.20

Program: HAP

Standard Text: Newly constructed and existing environments are designed and maintained to comply with the Life Safety Code®.

Secondary Priority Focus Area(s) Physical Environment

Element(s) of Performance

Scoring Category : B
1. Each building in which patients are housed or receive care, treatment, and services complies with the LSC, NFPA 101® 2000; OREach building in which patients are housed or receive care, treatment, and services does not comply with the LSC, but the resolution of all deficiencies is evidenced through the following:

An equivalency approved by the Joint Commission Or

Continued progress in completing an acceptable Plan For Improvement (Statement of Conditions™, Part 4)

Surveyor Findings

See Life Safety Code Report

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Rights & Ethics

Standard: RI.2.60

Program: HAP

Standard Text: The hospital addresses the wishes of the patient relating to end of life decisions.

Secondary Priority Focus Area(s) Communication

Element(s) of Performance

Scoring Category : C
21. The policies are consistently implemented.

Surveyor Findings

EP 21
Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
The advance directive section of the initial nursing assessment was not completed as required by the organization's policy and procedure. Documentation did not support any follow up to obtain this information. The patient was admitted to the organization on December 8, 2006.

Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
On a second individual tracer, the advance directive section of the initial nursing assessment was not completed as required by the organization's policy and procedure. Documentation did not support any follow up to obtain this information. The patient was admitted to the organization on February 16, 2007.

The Joint Commission

Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160

Evidence of Standards Compliance Received: 4/19/2007

PROGRAM(S)

Hospital Accreditation Program

Executive Summary

As a result of the accreditation activity conducted on the above date, your organization must submit a Measure of Success (MOS) within four (4) months from the day this report is posted to your organization's extranet site. If your organization does not make sufficient progress in the area(s) noted below, your accreditation may be negatively affected.

- The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

Program	Standard	Level of Compliance
HAP	PC.11.40	Compliant
HAP	Requirement 2C	Compliant

The Joint Commission

Select Specialty Hospital - Memphis, Inc.

5959 Park Avenue, 12th Floor

Memphis, TN 38119

Organization Identification Number: 148160

Date(s) of Survey: 4/19/2007 - 4/19/2007

PROGRAM(S)

Laboratory Accreditation Program

SURVEYOR(S)

Kathleen F. Cross, MT

Executive Summary

As a result of the accreditation activity conducted on the above date, your organization must submit Evidence of Standards Compliance (ESC) within 45 days from the day this report is posted to your organization's extranet site. If your organization does not make sufficient progress in the area(s) noted below, your accreditation may be negatively affected.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Staffing

Standard: QC.1.40

Program: LAB

Standard Text: The laboratory performs proficiency sample testing in the same manner as patient sample testing.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
2. Proficiency samples are tested along with the laboratory's regular patient testing workload by staff that perform the laboratory's testing.Note: Proficiency testing samples should be rotated among the personnel who perform the test.

Surveyor Findings

EP 2
Observed in Proficiency Testing at Select Specialty Hospital - Memphis, Inc. site for CLIA # 44D0927731.
The blood gas laboratory was not rotating proficiency testing specimens among the testing personnel. All proficiency testing was assayed by one of three employees and the patients' samples could be tested by one of eighteen employees. It is recommended that proficiency testing specimens be rotated among testing personnel so they are truly treated as patient specimens. The results also may be used in assessing personnel competency.

The Joint Commission

Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160

Evidence of Standards Compliance Received: 6/7/2007

PROGRAM(S)

Laboratory Accreditation Program

Executive Summary

There is no follow-up due to the Joint Commission as a result of the accreditation activity conducted on the above date.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

Program	Standard	Level of Compliance
LAB	QC.1.40	Compliant

The Joint Commission

Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160
Measure of Success Received: 8/29/2007

PROGRAM(S)

Hospital Accreditation Program

Executive Summary

There is no follow-up due to The Joint Commission as a result of the accreditation activity conducted on the above date.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
781-B AIRWAYS BOULEVARD
JACKSON, TENNESSEE 38301

February 4, 2009

Mr. David Key, Administrator
Select Specialty Hospital
5959 Park Avenue, 12th Floor
Memphis, TN 38119

RE: Licensure Survey

Dear Mr. Key:

On January 12, 2009 a licensure survey was completed your facility. Your plan of correction for this survey has been received and was found to be acceptable.

Thank you for the consideration shown during this survey.

Sincerely,

Celia Skelley, MSN, RN
Public Health Nurse Consultant II

CES/TJW

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

2012 DEC 21 PM 12 21

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 14 day of December, 2012 a Notary
(Month) (Year)

Public in and for the County/State of Davidson / Tennessee.

NOTARY PUBLIC

My commission expires August 16, 2016.
(Month/Day) (Year)

BEVIN M. SHELLENBERGER
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY

My Commission Expires August 6, 2016

SUPPLEMENTAL # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
H 675	1200-8-1-.06 (4)(b) Basic Hospital Functions (4) Nursing Services. (b) The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The chief nursing officer must be a licensed registered nurse who is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This Rule is not met as evidenced by: Based on facility policy, medical record review, observation and interview, it was determined the nursing services failed to be organized in a manner to ensure assessments were accurate to trigger appropriate nutritional consults and physician's orders were followed for 3 of 5 (Patients # 2, 4 and 5) patients reviewed. The findings included: 1. Review of facility policy revealed the facility used an initial nutrition screen with a numerical system to ensure patients at moderate or high nutritional risk were referred for a nutrition consult. The assessment documented that a number 3 or higher required a referral to the Registered Dietitian (RD). Medical record review revealed Patient #4 was admitted on 1/8/09 with an infected surgical site and a stage 4 sacral wound. The assessment for this patient documented the patient had a wound and was assessed a 3 or at moderate risk on the initial nursing nutrition screen.	H 675

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

TATE FORM 6899

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3138 - 08627

Tag - # H 675:

Nursing Services

#1) Assessments and Communications with Dietary

1. Upon admission, the admitting/primary nurse will complete assessment. Triggers and prompts on admission assessment may indicate nutritional consult.
2. Process in place on 1/16/09
   a. Admitting/Primary Nurse will log nutritional consult in Dietary Referral Log
   b. Admitting/Primary Nurse will write an order for nutritional consult
   c. Unit secretary will enter order in system and records order number on medical record and log book
   d. RD to view Dietary Referral Log book and computer ordering system daily for any new consults
   e. RD will have admission assessment available for reference via nurse chart.
3. Nursing staff will be required to under go training. Failure to do so will result in suspension pending completion. Training will begin on 1/26/09 by Manager and DCS and will be completed by all nursing staff by 2/28/2009. Ongoing education will be via memos, education board, shift safety briefings and staff meetings.

FORM APPROVED 01/14/2009

December 21, 2012 01:16pm

Division of Health Care Facilities

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TATE FORM 6899 N

3138-08628

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4. Staff failure to follow process once training complete will be subject to disciplinary action up to termination.
5. Audits will occur weekly times 12 weeks by Nurse Manager, and DCS starting 2/2/09, then ongoing randomly through December 2009 to assure compliance of >90%.
6. Results will be shared with staff at meetings, and posted on staff PI board.
7. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

Tag - # H-675

Nursing Services
#2 Calorie Counts

1. Order will be written by RD or physician for calorie count
2. RD to email DCS and DQM when calorie count order written for "real time" staff compliance monitoring to start 2/3/09.
3. Nursing staff will be required to under go training on calorie count importance and documentation. Failure to do so will result in suspension pending completion. Training will start on 1/26/09 by Nurse Manager and DCS and will be completed by all nursing staff by 2/28/2009. Ongoing education regarding calorie counts will be via memos, education board, shift safety briefings and staff meetings.

SUPPLEMENTAL # 1

December 21, 2012

Division of Health Care Facilities

01:16pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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H 675	Continued From page 1 Medical record review revealed Patient #5 was admitted on 1/6/09 with respiratory distress and with a stage 3 wound. The assessment for this patient documented a 6 on the initial nursing nutrition screen or at high risk. During an interview on 1/12/09, at 2:01 PM, the RD confirmed nutrition services had not received an order for a nutrition consult for either Patient #4 or Patient #5. The RD stated he/she was not aware Patient #4 had a wound when he/she did the nutrition assessment. During an interview on 1/12/09, at 2:44 PM, the Clinical Director confirmed both Patients #4 and 5 should have had an order for a nutrition consult. He/she stated the system nursing services was using to contact for nutrition services was not working. During an interview on 1/12/09, at 2:44 PM, the wound care nurse stated he/she had just completed the wound assessment with pictures and staging. The nurse confirmed this information had not been in the medical record when the nutrition assessment was completed on 1/9/09 by the RD. 2. Medical record review for Patient #2 documented a physician's order dated 1/7/09 for a 72 hour Calorie Count from 1/8/08 - 1/10/09. Review of the "Calorie Count" documentation for 1/9/09 revealed no information had been documented. During an interview on the meeting on 1/12/09 at 3:05 PM, the RD verified the Calorie Count information was incomplete.	H 675

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4. Staff failure to follow process after training complete will be subject to disciplinary action up to termination.
5. RD to email DCS calorie count result on each patient starting 2/3/09.
6. RD will be educated on DCS communication process by DCS/DQM by 2/2/09.
7. Audits will occur weekly times 12 weeks by Nurse Manager and DCS starting 2/2/09, then randomly to assure compliance of >90%.
8. Results will be shared with staff at meetings, and posted on staff PI board.
9. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

Tag - # H-675

Nursing Services Part 2 of #2:
Nutritional Supplements

1. Nursing Staff will be required to under go training on Treatment Administration Record and documentation. Failure to do so will results in suspension pending completion. Training will start on 1/26/09 by Nurse Manager and DCS and will be completed by all nursing staff by 2/28/2009. Ongoing education of dietary supplements will be via memos, education board, shift safety briefings and staff meetings.
2. Staff failure to follow process once training complete will be subject to disciplinary action up to termination.
3. Audits will occur weekly times 12 weeks by Nurse Manager and DCS

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H 675	Continued From page 1 Medical record review revealed Patient #5 was admitted on 1/6/09 with respiratory distress and with a stage 3 wound. The assessment for this patient documented a 6 on the initial nursing nutrition screen or at high risk. During an interview on 1/12/09, at 2:01 PM, the RD confirmed nutrition services had not received an order for a nutrition consult for either Patient #4 or Patient #5. The RD stated he/she was not aware Patient #4 had a wound when he/she did the nutrition assessment. During an interview on 1/12/09, at 2:44 PM, the Clinical Director confirmed both Patients #4 and 5 should have had an order for a nutrition consult. He/she stated the system nursing services was using to contact for nutrition services was not working. During an interview on 1/12/09, at 2:44 PM, the wound care nurse stated he/she had just completed the wound assessment with pictures and staging. The nurse confirmed this information had not been in the medical record when the nutrition assessment was completed on 1/9/09 by the RD. 2. Medical record review for Patient #2 documented a physician's order dated 1/7/09 for a 72 hour Calorie Count from 1/8/08 - 1/10/09. Review of the "Calorie Count" documentation for 1/9/09 revealed no information had been documented. During an interview on the meeting on 1/12/09 at 3:05 PM, the RD verified the Calorie Count information was incomplete.	H 675

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starting 2/2/09, then randomly to assure compliance of >90%
4. Results will be shared with staff at meetings, and posted on staff PI board.
5. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

Tag - # H-733

Food and Dietetic Services:
#1) Wound Assessments:

1. Wound assessments will be done on admission by admitting nurse.
2. RD will review wound assessments on medical record or in nurse chart.
3. For any nutritional consults ordered upon admission, RD will review chart and nurse assessment for determination of patient's nutritional needs.
4. RD will be educated on process by 2/2/09 by DCS or DQM.
5. Failure of RD to follow process once training completed will be reported to host Director of Nutrition Services and will be subject to termination of contracted employment at SSH for this individual.
6. Audits will occur weekly times 12 weeks by Nurse Manager and DCS starting 2/2/09, then randomly to assure compliance of >90%
7. Results will be shared with staff at meetings, and posted on staff PI board.
8. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Reports of audits will be reported through December 2009.

Division of Health Care Facilities

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H 675	Continued From page 2 Medical record review for Patient #4 revealed an order, dated 1/9/09, for Enure plus with meals . During an interview on 1/12/09, at 1:00 PM, Patient #4 stated he/she had not receive any ensure until lunch on 1/11/09 and then received 2 cans at the same meal. The Patient further stated he/she did not receive any ensure at the dinner meal on 1/11/09 or for breakfast on 1/12/09. On 1/12/09, the Physician again ordered Ensure plus at 1 can TID (three times each day). During an interview on 1/12/09, at 2:30 PM, the Clinical Nurse Manager was unable to find any documentation the Ensure plus had been given prior to 1/11/09.	H 675	Tag – #H-733 Food and Dietetic Services #2) Nutritional Assessments upon admission: 1. Upon admission, the admitting/primary nurse will complete assessment. Triggers and prompts on admission assessment may indicate nutritional consult. 2. Process in place on 1/16/09 a. Admitting/Primary Nurse will log nutritional consult in Dietary Referral Log b. Admitting/Primary Nurse will write an order for nutritional consult c. Unit secretary will enter order in system and records order number on medical record and log book d. RD to view Dietary Referral Log book and computer ordering system daily for any new consults e. RD will have admission assessment available for reference via nurse chart. 3. Nursing staff will be required to under go training. Failure to do so will result in suspension pending completion. Training will start on 1/26/09 by Nurse Manager and DCS and will be completed by all nursing staff by 2/28/2009. Ongoing education will be via memos, education	
H 733	1200-8-1-.06 (9)(c) Basic Hospital Functions (9) Food and Dietetic Services. (c) There must be a qualified dietitian, full time, part-time, or on a consultant basis who is responsible for the development and implementation of a nutrition care process to meet the needs of patients for health maintenance, disease prevention and, when necessary, medical nutrition therapy to treat an illness, injury or condition. Medical nutrition therapy includes assessment of the nutritional status of the patient and treatment through diet therapy, counseling and/or use of specialized nutrition supplements. This Rule is not met as evidenced by: Based on facility policy, medical record review,	H 733		

SUPPLEMENT # 1
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December 21, 2012

Division of Health Care Facilities

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
H 676	Continued From page 2 Medical record review for Patient #4 revealed an order, dated 1/9/09, for Ensure plus with meals . During an interview on 1/12/09, at 1:00 PM, Patient #4 stated he/she had not receive any ensure until lunch on 1/11/09 and then received 2 cans at the same meal. The Patient further stated he/she did not receive any ensure at the dinner meal on 1/11/09 or for breakfast on 1/12/09. On 1/12/09, the Physician again ordered Ensure plus at 1 can TID (three times each day). During an interview on 1/12/09, at 2:30 PM, the Clinical Nurse Manager was unable to find any documentation the Ensure plus had been given prior to 1/11/09.	H 676
H 733	1200-8-1-.06 (9)(c) Basic Hospital Functions (9) Food and Dietetic Services. (c) There must be a qualified dietitian, full time, part-time, or on a consultant basis who is responsible for the development and implementation of a nutrition care process to meet the needs of patients for health maintenance, disease prevention and, when necessary, medical nutrition therapy to treat an illness, injury or condition. Medical nutrition therapy includes assessment of the nutritional status of the patient and treatment through diet therapy, counseling and/or use of specialized nutrition supplements. This Rule is not met as evidenced by: Based on facility policy, medical record review,	H 733

board, shift safety briefings and staff meetings.
4. Audits will occur weekly times 12 weeks by Nurse Manager, and DCS starting 2/2/09, then ongoing randomly to assure compliance of >90%.
5. Results will be shared with staff at meetings and posted on staff PI board.
6. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

Tag - #H-733

Food and Dietetic Services
#3 & #4) Wound and Dietary Assessment and Implementation of Orders

1. RD will review wound assessments on medical record or in nurse chart.
2. Wound care RN or Charge Nurse will notify DCS of any wound care admissions for additional follow up on nutritional screening and order implementation.
3. RD will be required to under go training on wound care manual and protocols, and location and accessibility of the wound care manual for reference by 2/2/2009. Failure to complete training will result in termination of contracted employment at SSH for this individual.
4. In-service information and signature sheet will be filed in the in-service manual by 2/9/09 at host facility.

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H 733	Continued From page 3 observation and interview, it was determined the facility RDs failed to follow the facility guidelines for developing a nutrition assessment to meet patient needs to heal pressure ulcers for 2 of 6 (Patient's # 4 and 6) reviewed and to ensure a Physician ordered calorie count was completed for Patient #4. The findings included: 1. Review of the hospital clinical services policy and procedure for patients with wounds, titled "Approach for Wound Care" revealed the following documentation: "Our wound care mission is to ensure prevention of new wounds and appropriate healing of present wound... Team members may include...ET Nurse and Dietician... The process for initiation of wound care included,.:. Nurse (RN) does an admission assessment....photographs wounds... Wound team members do an assessment and make recommendations to the MD (Medical Doctor)." 2. Review of the hospital wound assessment policy and procedure revealed the following documentation: "All patients admitted for wound care will have a comprehensive nutritional assessment done within 72 hours of admission. The goal ... is to ensure that the diet of the patient with a wound contains nutrients adequate to support healing... This normally consists of 30-35 calories/kg (kilogram)/day and 1.25-1.5 grams of protein/kg/day. For severe wounds, this may need to be increased to 40 calories/kg/day and 2.0 grams of protein/kg/day." 3. Patient #4 was admitted on 1/8/09 with	H 733	5. Quarterly random chart reviews will be conducted to ensure patient care is in compliance with protocols by host facility RD Manager. 6. RD Manager quarterly chart review results will be shared with SSH DCS and DQM for compliance. 7. Results will also be reported by DCS/DQM quarterly to MEC and Governing Board. Audit results will be reported through December 2009.	

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H 733	Continued From page 4 diagnoses which included an infected right hip with methicillin resistant staph (MRSA) and Sepsis. On 1/9/09, at 7:45 AM, the Physician progress notes documented, "Skin care and decubitus protection and care of ulcer on bottom.... Wound care consult." On 1/9/08 the wound care nurse documented the wound to be a stage 4 sacral wound. The wound was measured to be 3.5 centimeters (cm) in length and 2.5 cm in width. The right hip incision was 4.6 cm with 1.5 cm of tunneling. The initial nutrition assessment done by the facility RD on 1/9/09 at 12:15 PM documented under diagnosis "...hardware removal from hip (bilateral hip surgery)". There was no documentation of a wound. This assessment documented the patient's height at 5 foot 3 inches and a current weight at 103 pounds. By skin assessment was documented, "to be assessed." The estimated calorie requirement was documented as 1100-1300 calories rather than the 1404-1872 calories using facility protocol of 30-40 calories kg for wound healing. Protein was estimated at 55-65 grams of protein rather than 68 grams of protein or higher for a severe wound according to facility protocol. During an interview on 1/12/09, at 2:01 PM, the RD stated he/she was not aware patient #4 had a wound. He/she confirmed the nutrition assessment was completed prior to the nursing wound assessment completed on 1/9/09 also. The RD stated he/she had not received a request for a nutrition consult based on the initial nursing nutrition assessment. 4. Patient #5 was admitted on 1/6/09, with diagnoses which included respiratory failure and	H 733		

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H 733	Continued From page 5 bowel obstruction. The resident's height was 64 inches and the weight 139 pounds. On 1/7/09, the wound care nurse documented a sacral stage 3 wound 2.5 cm by 1.0 cm in the wound care progress note. On 1/7/09, the nutrition assessment, completed by the RD, documented the wound as stage 2 to the sacral area rather than the stage 3 wound documented by the wound care nurse. The RD assessed the patient required 1.0-1.4 gm/kg of protein rather than 1.25-1.5 gm/kg of protein according to facility protocol. The fluid requirement was estimated to be 1260-1575 milliliters (ml) per kg per day using 20-25 ml of fluid per kg, rather then the 1895 ml or a minimum of 1500ml per day that would have been estimated if the facility protocol of 30-35 ml of fluid per kg per day for wounds had been followed. The RD assessed the current tube feeding product to contain 848 ml of free water but did not assess the total current fluid intake to see if it met the patient's nutritional requirements. During an interview on 1/12/09, at 2:00 PM, the facility RD confirmed the assessment did not meet the facility standard of practice.	H 733		
H 738	1200-8-1-.06 (9)(f) Basic Hospital Functions (9) Food and Dietetic Services. (f) Education programs, including orientation, on-the-job training, inservice education, and continuing education programs shall be offered to dietetic services personnel on a regular basis. Programs shall include instruction in personal hygiene, proper inspection, handling, preparation	H 738		

SUPPLEMENTAL # 1

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H 738	Continued From page 6 and serving of food and equipment. This Rule is not met as evidenced by: Based on review of dietary policies and procedures, observations and interviews, it was determined the facility failed to provide adequate education programs on sanitation. The findings included: 1. Review of facility continuing education programs revealed only one inservice in the last year on sanitation and this was dated 10/08. 2. During an initial tour of the kitchen on 1/12/09, from 9:30 AM to 10:30 AM, a dietary supervisor was observed washing hands with a procedure that re-contaminated the hands. A dietary employee was questioned and was unable to determine the correct amount of sanitizer in the 3 compartment sink. 3. During an interview on 1/12/09, at 10:30 AM, the Dietary Director confirmed that for 2008, all topics which included sanitation, personal hygiene and instruction on handling food and equipment to ensure adequate sanitation were all presented in this 1 inservice.	H 738	Tag - #H-738 Food and Dietetic Services #1, - #3) In-services, Handwashing and Sanitizer 1) Host staff will be required to under go sanitation in-services and in-services will be documented and signature sheets will be filed in the in-service manual by 2/26/2009. 2) Host staff will be required to under go re-education on proper handwashing technique by 2/26/2009. 3) Nutrition Services employees will be in-serviced on correct sanitizing processes to include PPM by 2/26/09. 4) Host in-service information and signature sheet will be filed in the in-service manual. 5) All ongoing in-services will be documented with signature sheets and filed in in-service manual. 6) Select Specialty Hospital COO and DQM will verify all required in-services at host facility have been	
H 742	1200-8-1-.06 (9)(j) Basic Hospital Functions (9) Food and Dietetic Services. (j) Written policies and procedures shall be followed concerning the scope of food services in accordance with the current edition of the "U.S. Public Health Service Recommended Ordinance and Code Regulating Eating and Drinking	H 742		

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SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 738	Continued From page 6 and serving of food and equipment. This Rule is not met as evidenced by: Based on review of dietary policies and procedures, observations and interviews, it was determined the facility failed to provide adequate education programs on sanitation. The findings included: 1. Review of facility continuing education programs revealed only one Inservice in the last year on sanitation and this was dated 10/08. 2. During an initial tour of the kitchen on 1/12/09, from 9:30 AM to 10:30 AM, a dietary supervisor was observed washing hands with a procedure that re-contaminated the hands. A dietary employee was questioned and was unable to determine the correct amount of sanitizer in the 3 compartment sink. 3. During an interview on 1/12/09, at 10:30 AM, the Dietary Director confirmed that for 2008, all topics which included sanitation, personal hygiene and instruction on handling food and equipment to ensure adequate sanitation were all presented in this 1 inservice.	H 738	held by 2/26/2009 and will audit weekly times 8 weeks starting 3/2/09 and randomly through December 2009 to ensure processes of handwashing and sanitation are being followed. 7) Failure of following process will be reported to Director of Nutrition Services. 8) Host employees failing to participate in required education and failure to follow processes will be subject to disciplinary actions per host facility and suspension of involvement with SSH pending completion. 9) Results will also be reported by DQM/COO in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.	
H 742	1200-8-1-.06 (9)(j) Basic Hospital Functions (9) Food and Dietetic Services. (j) Written policies and procedures shall be followed concerning the scope of food services in accordance with the current edition of the "U.S. Public Health Service Recommended Ordinance and Code Regulating Eating and Drinking	H 742		

Page 7 of 9 #2

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE [illegible] TO THE APPROPRIATE	(X5) COMPLETE DATE
H 742	Continued From page 7	H 742	Tag - #H-742	

Establishments" and the current "U.S. Public Health Service Sanitation Manual" should be used as a guide to food sanitation.

This Rule is not met as evidenced by:
Based on review of dietary policies and procedures, observations and interviews, it was determined the facility failed to follow the facility policy on jewelry use and to follow acceptable standards of practice for hand washing and use of the three compartment sink.

The findings included:

1. Review of facility policies and procedure revealed a policy that stated only wedding bands could be worn by dietary employees and they could not wear earrings or watches.

2. During an initial tour of the kitchen on 1/12/09, at 9:30 AM, a dietary employee was observed wearing earrings which dangled down from the ear.

3. During this tour on 1/12/09, at 9:45 AM, the Surveyor asked the Dietary Director to have someone demonstrate hand washing in the kitchen. A kitchen supervisor washed his/her hands in the hand washing sink, dried the hands and then lifted a cover from a trash can to discard the paper towels thereby recontaminating the hands.

4. During the initial tour of the kitchen, at 10:00 AM, a dietary employee was observed washing pots and pans in the 3 compartment sink. The Surveyor asked the employee to use a test strip to determine if the correct amount of sanitizer

Food and Dietetic Services
1 - # 4) Failure to follow policies

1) Policy discrepancies identified. Policy revisions/updates for type of jewelry allowed to be worn will be completed by 2/23/09 by Director of Nutrition Services.
2) Staff will be required to participate in in-services regarding policy revisions and updates by 2/26/09.
3) Staff will be required to participate in education regarding handwashing technique and 3 compartment sink by 2/26/2009.
4) In-service information and signature sheets will be filed in the in-service manual.
5) Select Specialty Hospital COO and DQM will verify all required in-services at host facility have been held by 2/26/2009 and will audit weekly times 8 weeks starting 3/2/09 and randomly through December 2009 to ensure processes are being followed.
6) Host employees failing to participate in required education and failure to follow processes will be subject to disciplinary action per host facility and suspension of involvement with SSH pending completion.
7) Results will also be reported by DQM/COO in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

SUPPLEMENTAL # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 742	Continued From page 8 was in the sink. The employee put the test strip into the water. The test strip came out a bright blue/green color. The Surveyor asked the employee if the test strip indicated the correct amount of sanitizer. The employee answered yes but was unable to tell the Surveyor the correct amount of sanitizer. Using the guide, the employee stated the reading was 500 but still stated the amount of sanitizer was correct. During an interview on 1/12/09, at 10:15 AM, the Dietary Manager confirmed the dietary supervisor should not have lifted the trash cover next to the hand washing sink and that the jewelry policy, in the facility policy and procedure manual, was probably old and they allowed stud earrings and watches to be worn in the kitchen.. The Dietary Manager also confirmed the test strip in the 3 compartment sink should have read 200 and there was too much sanitizer in the final rinse. He further stated	H 742		

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

AFFIDAVIT

2012 DEC 21 PM 12 22

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: SELECT SPECIALTY HOSPITAL-MEMPHIS

I, John Wellborn, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 21st day of Dec., 2012, witness my hand at office in the County of Rutherford, State of Tennessee.

NOTARY PUBLIC

My commission expires August 22, 2016

HF-0043

Revised 7/02

AMANDA L. JONES
STATE OF TENNESSEE NOTARY PUBLIC
RUTHERFORD COUNTY

My Commission Expires Aug. 22, 2016

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

March 1, 2013

John L. Wellborn, Consultant
Development Support Group
4219 Hillsboro Road, Suite 203
Nashville, TN 37215

RE: Certificate of Need Application -- Select Specialty Hospital-Memphis - CN1212-062

Dear Mr. Wellborn:

This is to acknowledge receipt of supplemental information to the referenced application for the addition of twenty-eight (28) long term acute beds to the exisitng thrity-nine (39) bed facility located in leased space at St. Francis Hospital, 5959 Park Avenue, Memphis (Shelby County), TN. Select Specialty will also add 10 beds under the statutory exemption available to hospitals with less than 100 beds found at TCA § 68-11-1607 (g) for a total licensed bed complement of seventy-seven (77) long term acute care beds. If the additional 28 beds are approved, St. Francis Hospital will reduce its license by 28 beds. The estimated project cost is $6,898,392.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on March 1, 2013. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on May 22, 2013.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Lori B. Ferranti, Director, TDH, PPA

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

MEMORANDUM

TO: Lori B. Ferranti, Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Cordell Hull Building, 6th Floor
425 Fifth Avenue North
Nashville, Tennessee 37247

FROM: Melanie M. Hill
Executive Director

DATE: March 1, 2013

RE: Certificate of Need Application
Select Specialty Hospital-Memphis - CN1212-062

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on March 1, 2013 and end on May 1, 2013.

Should there be any questions regarding this application or the review cycle, please contact Mark Farber, Deputy Director.

Enclosure

cc: John L. Wellborn, Consultant

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

December 19, 2012

John Wellborn
4219 Hillsboro Road, Suite 203
Nashville, Tennessee 37215

RE: Certificate of Need Application CN1212-062
Select Specialty Hospital-Memphis, Inc.

Dear Mr. Wellborn:

This will acknowledge our December 14, 2012 receipt of an application for a Certificate of Need for the addition of twenty-eight (28) long term acute care beds to Select Specialty Hospital-Memphis.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Wednesday December 26, 2012. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section A, Applicant Profile, Item 6**

   Please submit a fully executed First Amendment to the Lease Agreement or an Option to Lease that indicates that the First Amendment to the Lease Agreement will be executed upon approval of this application.

2. **Section A, Applicant Profile, Item 13**

   Does the applicant anticipate establishing a contract with United Healthcare Community Plan?

   Why did TennCare Select deny a contract request?

3. **Section B, Project Description, Item I.**

   Please describe the conditions that are typical for defining a long-term acute patient and the typical treatments and services provided to these patients.

4. **Section B, Project Description, Item II.A.**

   Please provide documentation from CMS that verifies the end of the LTACH bed moratorium at the end of 2012.

5. **Section B, Project Description, Item II.C.**

   Please provide the applicant referral source mix (locations from where patients are referred). What percentage of the applicant's patients are referred from St. Francis Hospital? Will this change after project completion? Is the applicant currently complying with the 25% threshold limit pertaining to referrals from the host hospital? If the applicant is receiving more than 25% of its referrals from St. Francis, please discuss the impact and ramifications of this situation.

   Please complete the following chart

LTACH Admissions to Select Specialty-Memphis
by Referral Source-Historical and Projected

Facility/Year	2011	2012	2014	2015	2016	2017
St. Francis Hospital						
St. Francis-Bartlett						
Baptist Mem. Hospitals						
Methodist Healthcare Hospitals						
The MED						
Surrounding County Hospitals						

Service Area Nursing Homes						
Patient Homes						
Other Referral Sources						

6. **Section B, Item III.A.**

   What is the size of the site in acres?

7. **Section B, Item III.B1.**

   Should the source for the distance tables read "Google Maps, Dec. 2012" instead of "2013"?

8. **Section C, Need, Item 1.a. (Long Term Care Hospital Beds-B. Economic Feasibility 1.)**

   Please provide the same information for all general acute care hospitals in Shelby County.

9. **Section C, Need, Item 3.**

   On page 34, second paragraph, did you mean to state "Only three of the twenty-one counties in this project's declared 43-county service area have shorter drive times to Memphis than to Nashville"?

10. **Section C, Need, Item 6**

    The methodology for projecting increased utilization is noted; however is the total growth to Year 2017 realistic where patient days are expecting to increase by 90% between 2012 and 2017?

    Is it also realistic to expect that this much of an increase in bed capacity will not have a significant impact on existing LTACH providers. The recently approved relocation of 24 LTACH beds to The MED will likely result in The Med reducing its current referral of LTACH patients to existing operating providers.

11. Section C. Economic Feasibility Item 1 (Project Cost Chart)

The submission of the letter supporting the construction cost estimate being submitted under separate cover is noted

12. Section C, Economic Feasibility, Item 10.

Which entity will actually be funding this project, Select Specialty-Memphis or its parent Select Medical Corporation? Document where in the financial statements provided are the funds for the proposed project.

13. Section C, Economic Feasibility, Item 11.

Has the applicant considered the alternative of delaying this project to evaluate the utilization of the recently added ten beds allowed by the "under 100 hospital bed" exemption and then adding additional ten bed increments if needed utilizing the exemption in the future.

14. Section C, Orderly Development, Item 3.

Table Twenty-Four is blank. Please complete the table.

15. Section C, Orderly Development, Item 7.

Survey findings and Joint Commission findings for Parkridge Medical Center were submitted. Please provide the information for Select Specialty Hospital-Memphis.

16. Affidavit

A signed and notarized affidavit must be submitted with each filing of an application and supplemental information. An affidavit was not included with this application. Please submit a completed affidavit for the original application and one for the supplemental information. Please note there is an affidavit form for the original filing and a separate form for supplemental responses.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application, the sixtieth (60th) day after written notification is Friday, February 15, 2012. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4)(d)(2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person.

Resubmittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ∋ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Mark A. Farber
Assistant Executive Director

MAF

Enclosure

Copy

Supplemental #1

Select Specialty Hospital - Memphis

CN1212-062

DSG Development Support Group

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

2012 DEC 21 PM 12 20

December 20, 2012

Mark Farber, Assistant Executive Director
Health Services and Development Agency
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: Certificate of Need Application CN1212-062
Select Specialty Hospital-Memphis, Inc.

Dear Mr. Farber:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section A, Applicant Profile, Item 6**
Please submit a fully executed First Amendment to the Lease Agreement or an Option to Lease that indicates that the First Amendment to the Lease Agreement will be executed upon approval of this application.

The applicant anticipates that an option to lease the additional floor will be fully executed by the parties this week, and will be submitted under separate cover, immediately thereafter.

2. **Section A, Applicant Profile, Item 13**
a. Does the applicant anticipate establishing a contract with United Healthcare Community Plan?
b. Why did TennCare Select deny a contract request?

The application was in error with respect to these plans. Attached is a revised page 4R. The applicant is in fact contracted with both TennCare Select and with BlueCare (the largest enrollment in the area).

On August 29, 2012, United's representative emailed Select Specialty that United preferred to negotiate on a case-by-case basis, rather than to have a contract. Select therefore has no reason to apply for a contract so soon after this decision.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

This is an existing facility, already certified for Medicare and Medicaid. No change in certification is anticipated.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

Approximately 75%-80% of an LTACH's admissions tend to be elderly, and include patients who are also Medicaid-eligible. Select Specialty Hospital-Memphis is currently contracted with the BlueCare TennCare MCO--which has West Tennessee's largest enrollment. Select is also contracted with TennCare Select.

TennCare and Medicaid patients from Mississippi and Arkansas are accepted on an individually negotiated basis.

The applicant's Medicaid days of care the past two years have averaged between 3% and 4% of its total days of care.

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
BlueCare (largest plan in W. TN)	Contracted
United Healthcare Community Plan (formerly AmeriChoice) (2nd largest plan)	Not contracted; admissions available on a negotiated basis
TennCareSelect (very small enrollment)	Contracted

3. Section B, Project Description, Item I.
Please describe the conditions that are typical for defining a long-term acute patient and the typical treatments and services provided to these patients.

LTACHS care for extremely ill patients who have been stabilized in a general acute care hospital, but remain too ill to be transferred to acute rehabilitation, skilled nursing, or home care. Most are elderly. They are medically fragile or unstable. They typically require acute care of several weeks' duration beyond what a short-term acute care hospital can afford to provide, with limited reimbursement from Medicare and commercial payors. Medicare has created this "second stage" environment especially for such patients, providing reimbursement for extended care beyond what a short-term hospital's DRG is designed to pay for. Typical lengths of stay in an LTACH exceed 25 days.

Typical conditions suitable for admission to LTACH include chronic respiratory disorders and other pulmonary conditions; cardiac, neurological, and renal conditions; infections and severe wounds. Many are medically complex cases, with a combination of issues that often require cardiac monitoring, long term antibiotic and nutritional therapies, pain control, and continued life support. One of Select Specialty Memphis's special strengths is its acceptance of ventilator-dependent patients, and their successful weaning from the ventilator. Programs of care are provided for patients with serious conditions such as multiple nervous system disorders, cardiovascular disorders, extended antibiotic therapy, patients with tracheotomies, ventilators, dialysis, TPN, burn care, oncological complications, dopamine for renal infusion, and numerous other post-surgical and complex medical conditions.

Services required for these patients include acute care nursing (5-8 hours per day), therapies (PT, OT, RT, Speech), diagnostic laboratory and imaging tests, surgery, nutritional control, and any type of service provided in the typical acute care setting. In this and other LTACH's, however, as indicated in the application, the host hospital contracts to provide many of these services within the LTACH itself, or downstairs in the hospital departments (surgery, imaging, etc.).

4. Section B, Project Description, Item II.A.
Please provide documentation from CMS that verifies the end of the LTACH bed moratorium at the end of 2012.

Please see the memorandum from CMS following this page. It is dated July 23, 2010. It notes that the Affordable Care Act extended the ending date of the moratorium until December 28, 2012.

Also, please see similar additional CMS materials at the back of this supplemental submission.

For more specific and detailed reference:

a. The Medicare, Medicaid, and SCHIP Extension Act of 2007 prohibited the establishment and classification of new LTACHs or satellites during the three calendar years (2008-2010) commencing on December 29, 2007.

b. The Patient Protection and Affordable Care Act subsequently extended this moratorium for an additional two years to December 28, 2012.

c. The Centers for Medicare & Medicaid Services applied the moratorium in its regulations at 42 CFR 412.23(e)(6), which states that "for the period beginning December 29, 2007 and ending December 28, 2012, a moratorium applies to the establishment and classification of a long-term care hospital or long-term care hospital satellite facility."

d. In a memorandum to State Survey Agency Directors, CMS specifically noted that "the Affordable Care Act extended the ending date of the moratorium from December 28, 2010 to December 28, 2012".

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C-10-25-Hospitals

DATE: **July 23, 2010**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Extension of Long-Term Care Hospital (LTCH) Moratorium

Memorandum Summary

- **LTCH Moratorium Extended:** A statutory moratorium prevents, with certain exceptions, the establishment of new LTCHs, an increase in existing LTCHs' number of certified beds, or the establishment of a satellite by an existing LTCH. The Affordable Care Act extended the ending date of the moratorium from December 28, 2010 to December 28, 2012.
- **No Changes to Administration of Moratorium:** The rules and policy for administering the moratorium, including the exceptions, the criteria for granting exceptions, and the methods to evaluate requests for exceptions, are not altered. Regional Offices must to rely upon the guidance in S&C-08-26, as updated by S&C-09-32.

Hospitals seeking to be excluded from the Medicare Hospital Inpatient Prospective Payment System for the first time as an LTCH must have a provider agreement with Medicare and must have an average Medicare inpatient length of stay (LOS) greater than 25 days, as provided under the existing regulations at 42 CFR 412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Social Security Act,. The Medicare Administrative Contractor (MAC) or legacy Fiscal Intermediary (FI), as applicable, verifies whether the hospital meets the average LOS requirement.

Section 114(d) of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) (Pub. L. 110-173), enacted December 29, 2007, established a three-year moratorium on the designation of new LTCHs or LTCH satellites, and on an increase of beds in an LTCH. The moratorium began on December 29, 2007 and was originally scheduled to end on December 28, 2010. However, Section 3106(a) of the "Affordable Care Act" (ACA) extended the ending date of the moratorium by two years. Therefore, the LTCH moratorium is now scheduled to end December 28, 2012. The LTCH moratorium regulation at §42 CFR 412.23(e)(6) will be updated to reflect that revision in the law.

S&C-08-26, issued June 13, 2008 and S&C-09-32, issued on April 17, 2009 provided detailed guidance on the process Centers for Medicare & Medicaid Services (CMS) Regional Offices and MACs/legacy fiscal intermediaries must use for evaluating applications for an exception to the moratorium under Section 114(d) of MMSEA. With the exception of the change in the moratorium end date, this guidance continues in effect. Copies of these memoranda are attached for your convenience.

Questions: If you have questions about the LTCH moratorium exception requirements, please contact Judith Richter via e-mail at Judith.richter@cms.hhs.gov. Survey and Certification operational questions should be directed to David Eddinger via e-mail at david.eddinger@cms.hhs.gov.

Effective Date: This guidance is effective immediately. Please ensure that all certification personnel are appropriately informed as to using this guidance within 30 days of this memorandum.

Training: The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators.

/s/
Thomas E. Hamilton

Attachments:

1. Expansion of Moratorium Exception on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds
2. Moratorium on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds

cc: Survey and Certification Regional Office Management

Section B, Project Description, Item II.C.

a. Please provide the applicant referral source mix (locations from where patients are referred). What percentage of the applicant's patients are referred from St. Francis Hospital? Will this change after project completion? Is the applicant currently complying with the 25% threshold limit pertaining to referrals from the host hospital? If the applicant is receiving more than 25% of its referrals from St. Francis, please discuss the impact and ramifications of this situation.

The referenced rule applies to Medicare admissions, not total admissions. Once called the "25% Rule", it has evolved somewhat.

Currently, no more than 50% of Select's total Medicare admissions can come from St. Francis, its host hospital, through 11-30-13. From 12-1-13 onward, that limit will be reduced to 25%, which is also the limit with respect to other admissions sources--except for the Baptist and Methodist systems.

Admissions from Baptist and Methodist can be up to 27.41% and 35.35% respectively, because both systems have a Medicare designation as a "market-dominant" provider to Medicare in their region. (Percentages apply to each licensed hospital or hospitals sharing a common provider number.)

During CY2012, approximately 20.2% of Select Specialty Hospital's Medicare admissions have been referred from St. Francis Hospital. In CY2011, this percentage was 20.5%. So Select is in compliance with the referral limitation rules of Medicare.

These percentages from St. Francis are not projected to change significantly after project completion. Select has always been, and will continue to be, in compliance with Medicare limitations on host hospital referrals.

Following this page are new historical and projection tables showing total and Medicare admissions from source hospitals. Select currently has no admissions from sources other than hospitals. In future years, between 1% and 2% of new admissions from patients' homes are anticipated by management.

SUPPLEMENTAL TABLE–HISTORICAL & PROJECTED ADMISSIONS TO SELECT SPECIALTY HOSPITAL-MEMPHIS BY REFERRAL SOURCE

1. LTACH Admissions to Select Specialty-Memphis ALL PAYOR CLASSES by Referral Source-Historical and Projected

Facility/Year	2009	2010	2011	2012	2014	2015	2016	2017
St. Francis Hospital	143	123	90	104	150	162	172	186
St. Francis-Bartlett	49	42	27	46	60	65	70	72
Baptist Mem. Hospitals	52	51	45	45	55	58	62	66
Methodist Healthcare Hospitals	116	116	103	139	151	158	165	170
The MED	45	27	40	29	29	31	32	32
Surrounding County Hospitals	59	67	113	98	225	271	333	351
Service Area Nursing Homes								
Patient Homes				5	7	8	9	10
Other Referral Sources								
TOTALS	464	426	418	466	677	753	843	887

2. LTACH Admissions to Select Specialty-Memphis MEDICARE ONLY by Referral Source-Historical and Projected

Facility/Year	2009	2010	2011	2012	2014	2015	2016	2017
St. Francis Hospital	103	83	60	63	95	105	112	124
St. Francis-Bartlett	28	25	23	34	47	50	53	55
Baptist Mem. Hospitals	43	37	31	34	45	48	52	55
Methodist Healthcare Hospitals	72	60	67	87	98	105	112	116
The MED	29	12	20	17	17	18	19	20
Surrounding County Hospitals	48	45	92	73	167	196	236	245
Service Area Nursing Homes								
Patient Homes				4	5	5	6	6
Other Referral Sources								
TOTALS	323	262	293	312	474	527	590	621

3. LTACH Admissions to Select Specialty-Memphis PERCENT OF MEDICARE ADMISSIONS BY SOURCE by Referral Source-Historical and Projected

Facility/Year	2009	2010	2011	2012	2014	2015	2016	2017
St. Francis Hospital	31.9%	31.7%	20.5%	20.2%	20.0%	19.9%	19.0%	20.0%
St. Francis-Bartlett	8.7%	9.5%	7.8%	10.9%	9.9%	9.5%	9.0%	8.9%
Baptist Mem. Hospitals	13.3%	14.1%	10.6%	10.9%	9.5%	9.1%	8.8%	8.9%
Methodist Healthcare Hospitals	22.3%	22.9%	22.9%	27.9%	20.7%	19.9%	19.0%	18.7%
The MED	9.0%	4.6%	6.8%	5.4%	3.6%	3.4%	3.2%	3.2%
Surrounding County Hospitals	14.9%	17.2%	31.4%	23.4%	35.2%	37.2%	40.0%	39.5%
Service Area Nursing Homes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Patient Homes	0.0%	0.0%	0.0%	1.3%	1.1%	0.9%	1.0%	1.0%
Other Referral Sources	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTALS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Hospital records.

b. Please complete the following chart:

LTACH Total Admissions to Select Specialty-Memphis
(by Referral Source-Historical and Projected

Facility/Year	2011	2012	2014	2015	2016	2017
St. Francis Hospital						
St. Francis-Bartlett						
Baptist Mem. Hospitals (2)						
Methodist Hospitals (4)						
The MED						
Surrounding County Hospitals						
Service Area Nursing Homes						
Patient Homes						
Other Referral Sources						

Please see the tables on the preceding pages, which supply this information and much more.

6. Section B, Item III.A.
What is the size of the site in acres?

The site of St. Francis Hospital is approximately 42 acres. Following this page is an amended site map showing that acreage.

7. Section B, Item III.B1.
Should the source for the distance tables read "Google Maps, Dec. 2012" instead of "2013"?

Yes, it should. Thank you. Attached after this page, following the site map, is a revised page 16R with the source footnote's date corrected on both tables.

8. Section C, Need, Item 1.a. (Long Term Care Hospital Beds-B. Economic Feasibility 1.)
Please provide the same information for all general acute care hospitals in Shelby County.

Attached after this page, following page 16R, is a revised page 22R with charge data from all Shelby County's general acute care hospitals added to Table Nine. With it is revised page 56R, Table Twenty-Two, with the same data.

9. Section C, Need, Item 3.
On page 34, second paragraph, did you mean to state "Only three of the twenty-one counties in this project's declared 43-county service area have shorter drive times to Memphis than to Nashville"?

No; and again thanks. It should read "... shorter drive times *to Nashville than to Memphis*." Attached after this page, following page 56R, is revised page 34R with that phrase corrected. Almost all service area counties are closer to this project than to Nashville LTACH's.

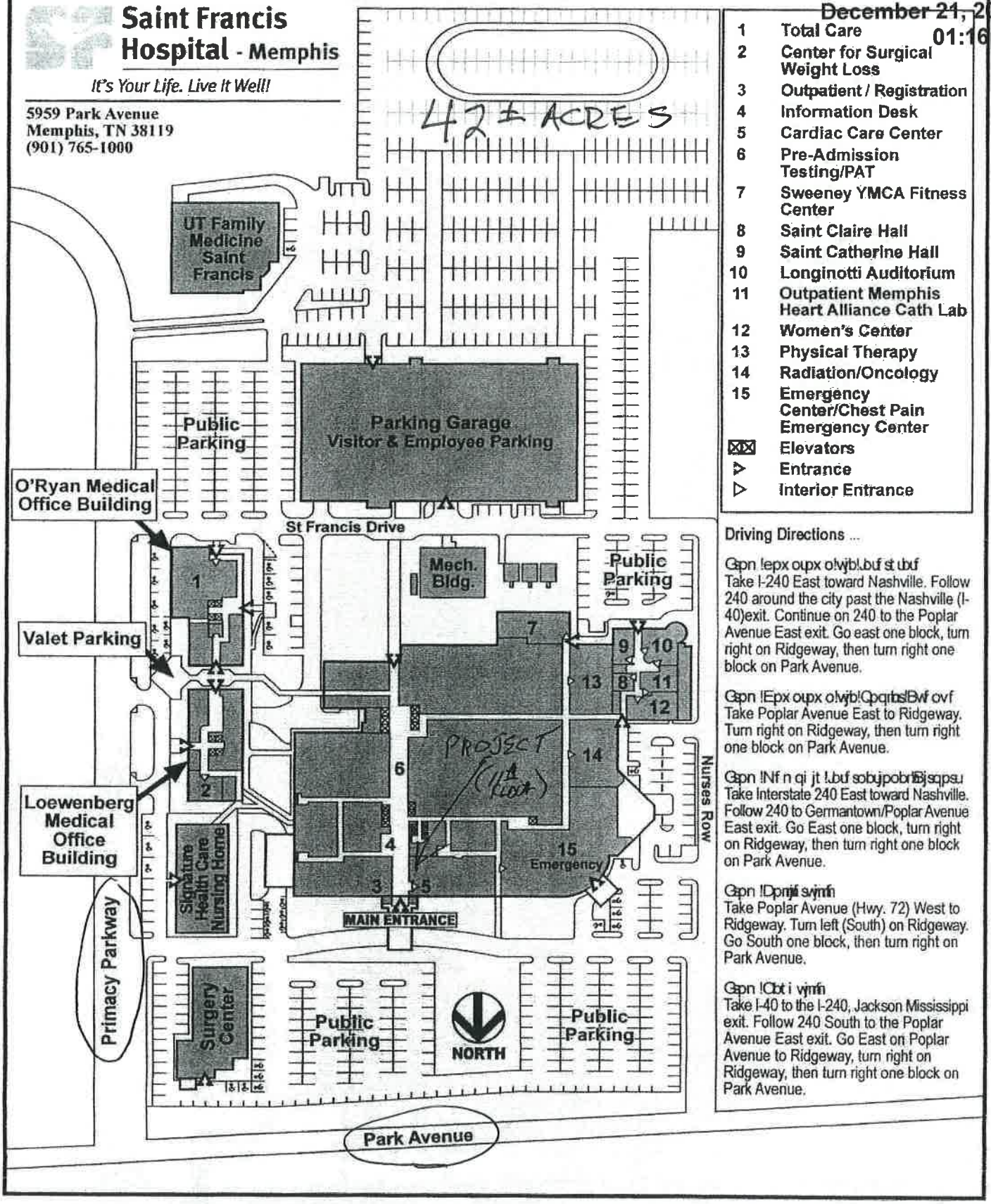
SUPPLEMENTAL- # 1

December 21, 2012
01:16pm

Saint Francis Hospital - Memphis

It's Your Life. Live It Well!

5959 Park Avenue
Memphis, TN 38119
(901) 765-1000



1	Total Care
2	Center for Surgical Weight Loss
3	Outpatient / Registration
4	Information Desk
5	Cardiac Care Center
6	Pre-Admission Testing/PAT
7	Sweeney YMCA Fitness Center
8	Saint Claire Hall
9	Saint Catherine Hall
10	Longinotti Auditorium
11	Outpatient Memphis Heart Alliance Cath Lab
12	Women's Center
13	Physical Therapy
14	Radiation/Oncology
15	Emergency Center/Chest Pain Emergency Center
⊠⊠	Elevators
▷	Entrance
▷	Interior Entrance

Driving Directions ...

Gspn !epx oupx o!wjb!.buf st.tbuf
Take I-240 East toward Nashville. Follow 240 around the city past the Nashville (I-40)exit. Continue on 240 to the Poplar Avenue East exit. Go east one block, turn right on Ridgeway, then turn right one block on Park Avenue.

Gspn !Epx oupx o!wjb!Qpqmbs!Bwf ovf
Take Poplar Avenue East to Ridgeway. Turn right on Ridgeway, then turn right one block on Park Avenue.

Gspn !Nf n qi jt !.buf sobjpobm!Bjsqpsu
Take Interstate 240 East toward Nashville. Follow 240 to Germantown/Poplar Avenue East exit. Go East one block, turn right on Ridgeway, then turn right one block on Park Avenue.

Gspn !Dpnj swjmm
Take Poplar Avenue (Hwy. 72) West to Ridgeway. Turn left (South) on Ridgeway. Go South one block, then turn right on Park Avenue.

Gspn !Cbt i wjmm
Take I-40 to the I-240, Jackson Mississippi exit. Follow 240 South to the Poplar Avenue East exit. Go East on Poplar Avenue to Ridgeway, turn right on Ridgeway, then turn right one block on Park Avenue.

Table Six: Mileage and Drive Times Between Project and Major Communities in the 17-County Primary Service Area			
Community	**County and State**	**Distance in Miles**	**Drive Time in Minutes**
1. Marion	Crittenden, AR	29.8	32"
2. Forrest City	Saint Francis, AR	65.2	64"
3. Corinth	Alcorn, MS	82.0	87"
4. Senatobia	DeSoto, MS	22.2	28"
5. Oxford	Lafayette, MS	70.6	83"
6. Tupelo	Lee, MS	101.0	99"
7. Holly Springs	Marshall, MS	40.1	46"
8. Batesville	Panola, MS	67.1	65"
9. Senatobia	Tate, MS	44.,8	46"
10. Dyersburg	Dyer, TN	77.5	100"
11. Somerville	Fayette, TN	42.2	44"
12. Trenton	Gibson, TN	89.7	102"
13. Ripley	Lauderdale, TN	55.5	78"
14. Jackson	Madison, TN	77.8	77"
15. Selmer	McNairy, TN	83.7	102"
16. Memphis	Shelby, TN	--	--
17. Covington	Tipton, TN	40.6	59"

Source: Google Maps, Dec. 2012

Table Seven: Mileage and Drive Times Between Project and the Three Other Approved Long Term Acute Care Hospitals in the 17-County Primary Service Area			
Facility and Address	**County and State**	**Distance in Miles**	**Drive Time in Minutes**
Select Specialty Hospital 5959 Park Avenue, Memphis, TN 38119	Shelby, TN	na	na
Baptist Memorial Restorative Care Hospital 2100 Exeter Road, Memphis, TN 38138*	Shelby, TN	3.1	5"
Methodist Extended Care Hospital 225 South Claybrook, Memphis, TN 38104	Shelby, TN	16.2	19"
Memphis Long Term Care Specialty Hospital 877 Jefferson Ave., Memphis, TN 38103	Shelby, TN	11.0	22"

Source: Google Maps, Dec. 2012

Table Nine: Comparative Charges Per Patient Day In Shelby County LTACH Facilities 2011 Joint Annual Reports / CN1210-052 (Mem.LT Care Spec'y)			
LTACH's	**Gross Inpatient Charges**	**IP or Discharge Days**	**Gross Charge Per Day**
Select Specialty CY 2011	$55,365,667	13,469	$4,111
Select Specialty CY 2015	$100,672,847	21,535	$4,675
Baptist Restor. Care CY2011	$44,353,983	8,267	$5,365
Methodist Ext. Care CY2011	$37,557,166	11,337	$3,313
Memph LT Care Spec CY2015	$28,143,153	8,322	$3,382
Average Gross Charge/Day, LTACH's in Shelby County	*$266,092,816*	*62,930*	*$4,228*
GENERAL HOSPITALS			
Baptist Memorial Hospital	$1,114,429,673	175,949	$6,334
Baptist Memorial Hospital Colliersville	$67,917,234	10,097	$6,726
Methodist Healthcare North	$368,520,300	58,820	$6,265
Methodist Healthcare South	$193,638,469	33,495	$5,781
Methodist Healthcare Germantown	$530,677,072	76,854	$6,905
Methodist LeBonheur Hospital	$436,975,498	56,884	$7,682
Methodist Healthcare University	$933,893,298	124,109	$7,525
Saint Francis Hospital	$812,315,392	89,083	$9,119
Saint Francis Hospital Bartlett	$281,098,187	29,947	$9,387
Delta Medical Center	$88,137,038	33,560	$2,626
The MED (Regl Med Center @ Mem)	$847,127,594	90,772	$9,332
Average Gross Charge/Day, General Hospitals in Shelby County	*$5,674,729,755*	*779,570*	*$7,279*

Source: Joint Annual Reports of Hospitals, 2011, pp. 18 & 24; CN1210-052 for Memphis Long Term Care Specialty Hospital; its data is for Year 1 (2015/16). Select Specialty data for 2015 is from this application.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

The requested Medicare comparison is provided in the table on the preceding page. The table below compares the most recently reported gross charge data for the two operating LTACH's and a third approved LTACH in this service area.

Table Twenty-Two: Comparative Charges Per Patient Day In Shelby County LTACH Facilities 2011 Joint Annual Reports / CN1210-052 (Mem.LT Care Spec'y)

LTACH's	Gross Inpatient Charges	IP or Discharge Days	Gross Charge Per Day
Select Specialty CY 2011	$55,365,667	13,469	$4,111
Select Specialty CY 2015	$100,672,847	21,535	$4,675
Baptist Restor. Care CY2011	$44,353,983	8,267	$5,365
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Methodist Healthcare University	$933,893,298	124,109	$7,525
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Average Gross Charge/Day, General Hospitals in Shelby County	*$5,674,729,755*	*779,570*	*$7,279*

Source: Joint Annual Reports of Hospitals, 2011, pp. 18 & 24; CN1210-052 for Memphis Long Term Care Specialty Hospital; its data is for Year 1 (2015/16). Select Specialty data for 2015 is from this application.

The declared 43-county service area is also validated by the fact that residents of almost all of its counties are closer to Select Specialty Hospital, than they are to LTACH's elsewhere.

In West and Middle Tennessee, the only LTACH facilities are in Memphis and Nashville. Only three of the twenty-one West Tennessee counties in this project's declared 43-county service area have shorter drive times to Nashville than to this project in Memphis. Similarly, all but two of the twenty-two Arkansas and Mississippi counties in the declared project service area are closer to Select Specialty Hospital than to LTACH's in their home states.

This is demonstrated by Table Fifteen on the following pages--listing the seventeen counties on the "perimeter" of the service area, which are closest to alternative LTACH's beyond this service area, in Nashville or adjoining States. Even in these perimeter counties, most residents have a shorter drive time to Memphis than to where the nearest alternative LTACH's are located. The shorter drive times for each comparison are bolded. And even for those few counties that are slightly closer to alternative LTACH's outside Memphis, there are special circumstances that justify their inclusion in a Memphis LTACH service area. Henry and Decatur County TN residents, for example, are much closer to Jackson tertiary care hospitals than to Nashville hospitals. If they seek hospital and specialty care in Jackson, many are more likely to be referred to Memphis than to Nashville, regardless of a small drive time differential. Similarly, Coahoma (Clarksdale) patients who typically seek care in Memphis will continue to drive the extra few miles to Memphis LTACH's than go to rural Mississippi for admission to the LTACH in rural Greenwood.

Further illustration that almost all these counties' access to Memphis is superior to their access to LTACH's in other locations is provided by Map Two on the second following page. Map Two has large stars marking the location of all alternative LTACH's in Mississippi, Arkansas, Alabama, and Middle and West Tennessee. (Small stars do not denote an LTACH). It can be seen that almost all the project service area counties are all closer to LTACH providers in Memphis than to LTACH's in any other city in these four States. Addresses of the alternative out-of-State LTACH's on Map Two are listed in the Attachments ("Miscellaneous").

10. Section C, Need, Item 6

a. The methodology for projecting increased utilization is noted; however is the total growth to Year 2017 realistic where patient days are expecting to increase by 90% between 2012 and 2017?

Select fully expects to double its admissions and patient days over the next five years. This is not unrealistic considering that we are dealing with small numbers. For example, the projections for CY2016, when Select will reach 85% occupancy, require only another 31 to 32 admissions per month over current levels.

This will be achieved in two ways--by working with medical staffs and administrations at current referral hospitals to increase the number of patients they refer to LTACH care; and by working with other hospitals in the region to become referral sources.

Review of Federal MEDPAR discharge data and personal meetings with management at both Jackson-Madison General Hospital (Jackson, TN) and North Mississippi Medical Center (Tupelo)--which are established referral sources for Select--have convinced Select that those two facilities can, and will, significantly increase their discharges to LTACH care.

And ten other hospitals in the region have been targeted as potential new referral sources for Select, once more beds become available in Memphis. Select will be a destination for many new referrals because of its reputation. Select offers special care programs of great interest--such as its unusually high success rates in weaning ventilator-dependent patients off their vents--a program developed by working with specialists at Duke Medical School.

It would be an error to regard the level utilization at the Memphis facilities the past four years as indication that no more demand exists. That would only be true if the LTACH's were not full. The fact is that this group of LTACH's have been at full occupancy for years, while turning away admissions. Their admissions have been level only from a lack of beds, caused by a Medicare moratorium that Medicare needed to develop more funding resources for this type of care.

b. Is it also realistic to expect that this much of an increase in bed capacity will not have a significant impact on existing LTACH providers. The recently approved relocation of 24 LTACH beds to The MED will likely result in The Med reducing its current referral of LTACH patients to existing operating providers.

Select does not anticipate that the MED will reduce its current referrals to existing LTACHs. The MED is going to open only 24 LTACH beds. Its CON application documented that the MED has enough qualified patients to fill 78 LTACH beds--54 more than the 24 beds they have just been approved to move to their campus. The MED also said that most of these patients are not now going to LTACH. So it is not clear that the MED's new beds will be filled at the expense of Methodist, Baptist, and Select referrals from the MED.

As for the other providers, Select believes that the majority of its additional admissions will come from hospitals outside Shelby County, for which Select is a closer provider than other LTACH's in other cities. This is based on discussions during site visits and on potential new referrals from smaller hospitals in the region that do not now discharge many patients to Memphis LTACHs.

There does not seem to be a reliable planning formula that can answer the question of how much additional LTACH bed need exists. The Guidelines formula of 0.5 beds per 10,000 service area population is possibly 15 years old. The population has aged since it was deemed appropriate. Aging increases the demand for LTACH services, because 80% of LTACH patients are of Medicare age. The 167 total LTACH beds that Memphis would have if this application is approved would give the service area only 0.7 beds per 10,000 population. It is hard to develop a bed need formula that is precise. And it should be remembered that this project does not construct any new bed spaces at all. It is just a productive use for existing beds that are now vacant.

a. Current approved LTACH beds = 139*
b. LTACH Beds if this CON application is approved = 167
c. CY2015 service area population = 2,433,814
d. 0.5 beds / 10,000 population = projection of 122 bed total need, Yr 2
e. 0.7 beds / 10,000 population = projection of 170 bed total need, Yr 2

* *39 existing+10 approved at Select; 24 approved at MED; 36 existing at Methodist; 30 existing at Baptist*

11. Section C. Economic Feasibility Item 1 (Project Cost Chart)
The submission of the letter supporting the construction cost estimate being submitted under separate cover is noted.

The contractor's letter attesting to the adequacy of the estimate is provided following this page. Also provided is the Cost PSF chart for Attachment B.II.A.

12. Section C, Economic Feasibility, Item 10.
Which entity will actually be funding this project, Select Specialty-Memphis or its parent Select Medical Corporation? Document where in the financial statements provided are the funds for the proposed project.

Select Specialty-Memphis will fund the project. In Attachment C, Economic Feasibility--10, there is a CY2012 (Jan-Oct) balance sheet for the hospital. Below the "Current Assets" section is a separate section named "Affiliates". In Affiliates, the line item entitled "Advances To" denotes an amount of cash that is held at Select Medical Corporation (the parent) on behalf of Select-Memphis (the hospital). In CY2012 (Jan-Oct) that amount was $14,814,576 (rounded). There is a similarly large fund in the CY2011 balance sheet.

Select-Memphis has access to that amount in the form of cash, to cover the project cost. This will not be treated as a loan from corporate; the hospital will not be charged interest on it. In practical terms, it is like a hospital savings account held at the parent company to earn interest. It is funded from prior years' earnings by this hospital, and held for its needs.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

BRASFIELD & GORRIE
GENERAL CONTRACTORS

December 20, 2012

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
161 Rosa Parks Boulevard
Nashville, TN 37203

RE: Select Specialty Hospital Memphis
Renovation of 11th Floor Nursing Unit – LTACH Beds

Dear Mrs. Hill:

We have reviewed Select Medical Corporation's construction cost estimate of $2,059,315 for renovation of a 21,677 SF nursing floor at Saint Francis Hospital, for additional LTACH beds. Based on discussions with Select's design and construction staff, and on our experience with similar projects, and on our knowledge of the current healthcare market, it is our opinion that this construction cost estimate is reasonable and sufficient to accomplish the proposed renovation.

Below is a summary of the current building codes that would apply to the project. This may not be totally inclusive, but it expresses Select's intent to address all applicable codes and standards, whether local, State, or Federal, in the design and construction of this project. The undersigned is a licensed contractor in the State of Tennessee.

- Guidelines for the Design and Construction of Health Care Facilities (current)
- Rules of the Tennessee Board for Licensing of Healthcare Facilities
- Standard Building Code
- National Electrical Code
- NFPA (National Fire Protection Code)
- ADA (Americans with Disabilities Act)

Sincerely,

Brasfield & Gorrie
Michael J. Dunn, Senior Project Manager
State of Tennessee ID # 00027321 Expiration date: 05/31/2013

cc: Dan Blaker, Select Medical Corporation
Todd Jackson, Brasfield & Gorrie

BRASFIELD AND GORRIE, LLC
3021 7th Avenue South Birmingham, Alabama 35233
P: 205.328.4000 F: 205.251.1304 W: BrasfieldGorrie.com

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Eleventh Floor										
Saint Francis Hospital										
38 Patient Rooms		7600 SF			7600 SF	0	7600 SF	$141.00	na	$1,071,600.00
Support Areas		14,077 SF			14,077 SF	0	14, 077 SF	$70.17	na	$987,715.00
B. Unit/Depart. GSF Sub-Total										
C. Mechanical/ Electrical GSF										
D. Circulation /Structure GSF										
E. Total GSF		21,677 SF			21,677 SF		21,677 SF	$95.00	$0	$2,059,315.00

13. Section C, Economic Feasibility, Item 11.

Has the applicant considered the alternative of delaying this project to evaluate the utilization of the recently added ten beds allowed by the "under 100 hospital bed" exemption and then adding additional ten bed increments if needed utilizing the exemption in the future.

Yes, but as stated on page 12 of the application, Select is offering to lease, license and renovate the entire floor at one time, prior to moving even the first ten patients onto it, in order to avoid subjecting patients on that floor to annual phased construction on that floor over the next four years. There are serious issues involved in construction in or near occupied nursing units. Phasing would make the project more costly and would increase patient risks from noise, infection issues, dust, etc.

Select believes that the better course of action is for the HSDA to approve Select's licensure of the remaining 28 beds on this floor, so that the entire floor can be renovated before moving any patients onto it. This would result in 28 more beds being licensed in 2014. The phased approach would result in the very same licensure by 2016--but at greater cost, and greater risk, from almost continuous construction proceeding in the midst of patient care.

14. Section C, Orderly Development, Item 3.
Table Twenty-Four is blank. Please complete the table.

Revised page 62R with Table Twenty-Four completed is attached following this page.

15. Section C, Orderly Development, Item 7.
Survey findings and Joint Commission findings for Parkridge Medical Center were submitted. Please provide the information for Select Specialty Hospital-Memphis.

Attached at the end of this supplemental response (due to its length) is the required information for this applicant.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

See Table Twenty-Four below for data from the Tennessee Department of Labor and Workforce Development. See the following page for Table Twenty-Five, showing current and projected FTE's and salary ranges for this project.

Table Twenty-Four: TDOL Surveyed Average Hourly Salaries for the Region

Position	Entry Level	Mean	Median	Experienced
RN	23.55	31.70	29.35	35.80
LPN	15.90	19.05	18.90	20.65
CNA	8.95	11.10	10.90	12.20
PT	31.25	40.95	39.75	45.80
PTA	21.10	28.20	29.95	31.75
OT	27.30	35.80	36.05	40.05
Resp. Therapist	19.85	23.55	23.50	25.40
Speech Therap.	22.80	31.35	30.10	35.60
Pharmacist	45.15	55.50	57.65	60.65
Pharmacy Tech	8.90	11.30	11.15	12.50

Source: 2012 Salary Surveys, Memphis Area, TN Dept of Labor & Workforce Dev'mt

16. **Affidavit**
A signed and notarized affidavit must be submitted with each filing of an application and supplemental information. An affidavit was not included with this application. Please submit a completed affidavit for the original application and one for the supplemental information. Please note there is an affidavit form for the original filing and a separate form for supplemental responses.

Please look between the submittal cover letter and the title page of the application. The affidavit is at that location in our photocopy of the December 14 filing. If you do not find it there, please accept the copy attached after this page.

Following this page there are two additional items. First is a revised Table Sixteen (Demography of the Service Area), with the latest 2010 Census median age data for the Tennessee primary service area counties. Second is a revised page 24R, that fills in a Table number that was previously omitted from the narrative.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

that patient. And once it does, Medicare begins to reimburse only at 80% of the hospital's cost of care—which further increases the free care by the hospital.

While this is not technically "charity" care, it is a necessary and substantial amount of free days of care contributed to many long-stay patients regardless of income. This uncompensated care is a large annual figure for Select. In 2011, more than a fifth (21%) of Select's total days were not reimbursed due to the FLO uncompensated care window applied by Medicare and other payors. The data in Table Eleven below show this facility's past three complete years of uncompensated days ("FLO days" that were incurrred. The Uncompensated Care column shows the applicant's gross charges during those days, minus any reimbursement later received for those patients after the fixed loss period ended. This is then shown as a percent of the hospital gross revenues. In the last full year (CY2011) Select provided this type of uncompensated care equal to 7.2% of hospital gross revenues. When 2012 data is compiled it will be similar to these years.

Table Eleven: Select Specialty Hospital-Memphis Uncompensated Care Days From FLO Process

Year	FLO (Fixed Loss Outlier) Days	Uncompensated Care	As a Percent of Gross Revenue	As a Percent of Total Facility Days
2009	2,406	$3,644,232	7.4%	17.9%
2010	2,500	$3,349,049	6.7%	19.7%
2011	2,846	$3,970,854	7.2%	21.1%

Source: Hospital management

C. Orderly Development

1. (a) Services offered by the long term hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional nursing (requiring 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

(b) Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

(c) Also, to avoid unnecessary duplication, the project should include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term hospitals.

Table Sixteen: Demographic Characteristics of TN Primary Service Area Counties (Supplemental) Of Select Specialty Hospital-Memphis 2013-2017

Demographic	SHELBY	DYER	FAYETTE	GIBSON	LAUDERDALE	MADISON	McNAIRY	TIPTON	PRIMARY SERVICE AREA	STATE OF TENNESSEE
Median Age-2010 US Census	34.6	39.3	41.9	39.9	36.4	36.8	41.6	36.6	NA	38.0
Total Population-2013	956,126	39,238	39,818	49,303	28,641	101,634	26,476	63,857	1,305,093	6,361,070
Total Population-2017	983,298	40,042	41,841	49,878	29,626	104,914	26,908	67,365	1,343,872	6,575,165
Total Population-% Change 2013 to 2017	2.8%	2.0%	5.1%	1.2%	3.4%	3.2%	1.6%	5.5%	3.0%	3.4%
Age 65+ Population-2013	103,296	5,910	5,960	8,634	3,937	13,277	4,910	7,541	153,465	878,496
% of Total Population	10.8%	15.1%	15.0%	17.5%	13.7%	13.1%	18.5%	11.8%	11.8%	13.8%
Age 65+ Population-2017	118,044	6,515	7,093	9,081	4,442	15,013	5,290	8,748	174,226	987,074
% of Population	12.0%	16.3%	17.0%	18.2%	15.0%	14.3%	19.7%	13.0%	13.0%	15.0%
Age 65+ Population-% Change 2013-2017	14.3%	10.2%	19.0%	5.2%	12.8%	13.1%	7.7%	16.0%	13.5%	12.4%
Median Household Income	$46,102	$38,909	$57,437	$37,577	$34,078	$40,667	$34,953	$50,869	$42,574	$43,314
TennCare Enrollees (08/12)	231,988	9,467	5,686	11,115	7,326	21,161	7,017	11,615	305,375	1,211,113
Percent of 2012 Population Enrolled in TennCare	24.3%	24.1%	14.3%	22.5%	25.6%	20.8%	26.5%	18.2%	23.4%	19.0%
Persons Below Poverty Level (2012)	192,181	7,534	4,659	8,825	7,246	19,514	5,957	9,770	255,686	1,049,577
Persons Below Poverty Level As % of Population (US Census)	20.1%	19.2%	11.7%	17.9%	25.3%	19.2%	22.5%	15.3%	18.9%	16.5%

Sources: TDH Population Projections, Feb. 2008; U.S. Census;
TennCare Bureau. PSA data is unweighted average or total of county data.
NR means not reported in U.S. Census source document.

See p. 5

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Fact Sheets

Details for: FINAL POLICY AND PAYMENT CHANGES FOR INPATIENT STAYS IN ACUTE-CARE HOSPITALS

Return to List

For Immediate Release: Wednesday, August 01, 2012

Contact: CMS Media Relations
202-690-6145

FINAL POLICY AND PAYMENT CHANGES FOR INPATIENT STAYS IN ACUTE-CARE HOSPITALS
AND LONG-TERM CARE HOSPITALS IN FY 2013

OVERVIEW: On August 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that will update Medicare payment policies and rates for inpatient stays in acute-care hospitals under the Inpatient Prospective Payment System (IPPS) and hospitals paid under the Long-Term Care Hospitals (LTCH) Prospective Payment System (PPS), in fiscal year (FY) 2013. The rule also finalizes the payment update that will be used to calculate FY 2013 target amounts for certain hospitals excluded from the IPPS, such as cancer and children's hospitals, and religious nonmedical health care institutions.

The rule, which will apply to approximately 3,400 acute-care hospitals and approximately 440 LTCHs, will generally be effective for discharges occurring on or after October 1, 2012. Under the rule, payment rates for inpatient stays in general acute-care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program will be increased by 2.8 percent. Those that do not successfully participate in the IQR Program will receive an increase of 0.8 percent (i.e., a 2.0 percentage point reduction). CMS projects that the rate increase—together with other policies established in the rule, the expiration of certain statutory provisions that provided special temporary increases in payments to hospitals, and other changes to the IPPS payment policy—will increase payments by about $2 billion in FY 2013, or 2.3 percent.

Medicare payments to LTCHs in FY 2013 are projected to increase by approximately $92 million or 1.7 percent. Provisions affecting LTCHs are described in more detail below in this fact sheet.

This fact sheet discusses major payment provisions of the final rule. A separate fact sheet on policies relating to the provision of high-quality care is available on the CMS web page at:

www.cms.gov/apps/media/fact_sheets.asp.

BACKGROUND: By law, CMS pays acute-care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. These prospective payment systems set rates prospectively based on the patient's diagnosis and the severity of the patient's medical condition. Under the IPPS and

the LTCH PPS, a hospital receives a single payment for the case based on the payment classification assigned at discharge: "MS-DRGs" under the IPPS and "MS-LTC-DRGs" under the LTCH PPS. Medicare law requires CMS to update the payment rates for IPPS hospitals annually to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients—known as the hospital "market basket"—as well as for other factors. Critical Access Hospitals (CAHs), children's hospitals, certain cancer hospitals, and certain other facilities do not receive payments under the IPPS.

Until FY 2008, discharges from acute-care hospitals were classified into one of 538 CMS-diagnosis-related groups (DRGs). In FY 2008, CMS replaced the 538 DRGs with 745 MS-DRGs that provide higher payments for more severely ill or injured patients and lower payments for all other cases. Since FY 2008, CMS has modified these MS-DRGs through notice and comment rulemaking, bringing the current total number of MS-DRGs to 751.

The LTCH PPS was implemented in FY 2003. Medicare payments under the LTCH PPS are based on the same DRG system as the IPPS, but payment weights associated with the LTCH patient classifications are calculated based on generally higher treatment costs at LTCHs. In conjunction with the IPPS, the LTCH PPS adopted MS-LTC-DRGs in FY 2008.

POLICIES AFFECTING ACUTE-CARE HOSPITALS

Changes to Payment Rates under IPPS: The rule will increase IPPS operating payment rates by 2.8 percent. This reflects an update of 2.6 percent for the hospital market basket adjusted by a multi-factor productivity adjustment of -0.7 percentage point and an additional -0.1 percentage point in accordance with the Affordable Care Act; this is increased by 1.0 percent for documentation and coding adjustments (more detail about these adjustments is included later in this fact sheet).

Policies to Continue Implementing the Affordable Care Act:

Hospital Readmissions Reduction Program: Section 1886(q) of the Social Security Act, as added by section 3025 of the Affordable Care Act, establishes the Hospital Readmissions Reduction

Program, which requires CMS to reduce payments to certain hospitals with excess readmissions, effective for discharges beginning on or after October 1, 2012.

In the FY 2012 IPPS/LTCH PPS final rule, CMS began implementation of the Readmissions Reduction Program and finalized the following policies:

- The use of three 30-day readmission measures—Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN), endorsed by the National Quality Forum for FY 2013 and FY 2014;
- The definition of "readmission" as generally referring to an admission to an acute-care hospital paid under the IPPS within 30 days of a discharge from the same or another acute-care hospital (subject to technical issues addressed in the rule);
- The calculation of a hospital's excess readmission ratio for AMI, HF and PN, which is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition; and

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- A policy to use three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio for each applicable condition. In FY 2013, the excess readmission ratio will be based on discharges occurring during the 3-year period of July 1, 2008 to June 30, 2011.

The FY 2013 IPPS/LTCH PPS Rule finalizes a methodology to calculate the readmissions adjustment factor, which is the higher of a ratio of a hospital's aggregate dollars for excess readmissions to their aggregate dollars for all discharges, or 0.99 (i.e., a 1.0 percent reduction) for FY 2013. CMS will apply the readmission adjustment factor to a hospital's base operating DRG payment amount and estimates that the Hospital Readmissions Reduction Program will result in a 0.3 percent, or approximately $270 million decrease in overall payments to hospitals.

Hospital Value-Based Purchasing (VBP) Program: The final rule addresses operational details relating to payment rates to hospitals in FY 2013 (the first year that the VBP program's payment implications will go into effect), as well as additional measures and policies that will affect value-based incentive payments for hospitals in FY 2015 and FY 2016.

For additional information about the Hospital VBP Program policies in this rule, please see the fact sheet on quality issues at: www.cms.gov/apps/media/fact_sheets.asp.

Documentation and Coding Adjustment:

The final rule will complete all documentation and coding adjustments for FY 2008 and FY 2009 as required by the TMA, Abstinence Education, and QI Programs Extension Act of 2007.

Below is a summary of documentation and coding adjustments that will affect the FY 2013 IPPS update:

Remaining FY 2008 and FY 2009 Prospective Documentation and Coding Adjustment	-1.9 percent
Restoration of One-Time 2012 Recoupment Adjustment	+2.9 percent
Total	+1.0 percent*

*This total is higher than the +0.2 percent adjustment that was included in the proposed rule because CMS did not finalize its proposal to make a prospective documentation and coding adjustment to account for estimated overpayments in FY 2010.

Other Changes in the IPPS/LTCH PPS Final Rule:

New Technology Add-On Payments For FY2013: To remove barriers to access for costly new technologies that are not yet fully reflected in the current MS-DRG payment rates, the Medicare law provides for temporary add-on payments for inpatient stays that involve the use of certain approved new technologies. CMS is approving new technology add-on payments for three applications, glucarpidase (Voraxaze®), fidaxomicin (DIFICID™), and the Zenith® Fenestrated Abdominal Aortic Aneurysm (AAA) Endovascular Graft.

Voraxaze® can be used to rapidly reduce toxic concentrations of methotrexate, a chemotherapy drug that can cause renal impairment in patients being treated for cancer. DIFICID™ is an oral medication used to treat *Clostridium difficile*-associated diarrhea (CDAD), a common hospital acquired illness that can result from treatment with antibiotics. The Zenith® Fenestrated AAA Endovascular Graft is an implantable device designed to treat patients who have an abdominal aortic aneurysm and but are not candidates for treatment with open surgery or other grafts on the market

because they have unique anatomical issues. Additionally, CMS is extending through FY 2013, the new technology add-on payment for the AutoLITT™, an MRI guided treatment for the removal of brain tumors.

Inclusion of Labor and Delivery Beds in the Available Bed Count for the Disproportionate Share Hospital (DSH) Adjustment and Indirect Medical Education (IME) Adjustment: CMS is finalizing inclusion of labor and delivery days in the count of available beds for purposes of both the Medicare DSH and IME adjustments. This change will align with the CMS policy, adopted in FY 2010, to include labor and delivery days in the patient day count for the Medicare DSH adjustment. CMS is also applying the timely filing requirements to the submission of no pay bills for purposes of calculating the DSH adjustment.

Postponement of "Services Under Arrangement" Requirements: In the FY 2012 IPPS/LTCH PPS final rule CMS finalized the policy that therapeutic and diagnostic services are the only services that may be furnished under arrangement outside of the hospital to Medicare beneficiaries. Routine services (that is, bed, board, and nursing and other related services) must be furnished by the hospital. Some hospitals have stated they need additional time to restructure existing arrangements and establish necessary operational protocols to comply with the policy. Therefore, CMS is postponing the effective date of the policy that limits "services under arrangement" to diagnostic and therapeutic services. This policy will now be effective for hospital cost reporting periods beginning on or after October 1, 2013.

Graduate Medical Education (GME): CMS is including several changes and clarifications of existing policy regarding GME in this rule. CMS is extending the timeframe for teaching hospitals that qualify to establish their caps for new programs from three years to five years. CMS is also making changes regarding the five-year period following the implementation of increases to hospitals' full-time equivalent (FTE) resident caps under section 5503 of the Affordable Care Act. CMS is changing and clarifying existing policy related to the application of section 5506 of the Affordable Care Act, which preserves resident cap positions from closed hospitals. In addition, CMS is clarifying that timely filing rules for claims submission apply to no-pay claims submitted by hospitals to receive indirect medical education, direct medical education and nursing and allied health education payments for Medicare Advantage beneficiaries.

Additions to the list of Hospital Acquired Conditions (HACs): CMS is adding two categories of conditions to the list of HACs in FY 2013, Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization.

For more information on quality-related provisions in this rule, please see www.cms.gov/apps/media/fact_sheets.asp.

Expiring Provisions:

Medicare-Dependent Hospital (MDH) Program: Under current law, the MDH program will expire at the end of FY 2012, that is, for discharges occurring after September 30, 2012. Accordingly, beginning in FY 2013, hospitals that are currently paid under the MDH program will instead be paid based on the Federal rate as are other IPPS hospitals (unless they can also qualify as sole community hospital) .

Low-Volume Hospital Payment Adjustment: Prior to 2011, a low- volume hospital had to be at least 25 miles from the nearest hospital and have less than 800 total discharges. For FY 2011 and FY 2012, sections 3125 and 10314 of the Affordable Care Act defined a low-volume hospital as being more than 15 road miles from other IPPS hospitals and having fewer than 1,600 Medicare discharges. Payment adjustments were made on a sliding scale with a higher adjustment for hospitals with fewer discharges and a lower adjustment for hospitals with higher discharges.

Effective for FY 2013 and forward, the low-volume hospital definition and payment adjustment methodology will return to the pre-2011 definition and payment adjustment methodology. Hospitals that qualify for the low-volume hospital adjustment will receive a 25 percent adjustment rather than an adjustment based on a sliding scale.

POLICIES AFFECTING LONG-TERM CARE HOSPITALS

Changes to Payment Rates under the LTCH PPS: CMS projects that LTCH PPS payments will increase by 1.7 percent, or approximately $92 million, in FY 2013. This estimated increase is attributable to several factors, including the update of 1.8 percent (based on a market basket update of 2.6 percent reduced by a multi-factor productivity adjustment of 0.7 percentage point and an additional 0.1 percentage point reduction in accordance with the Affordable Care Act); the "one-time" budget neutrality adjustment of approximately -1.3 percent (the first year of a 3 year phased-in adjustment) to the FY 2013 standard Federal rate (which is not applicable to payments for discharges occurring on or before December 28, 2012); and, projected increases in estimated high cost outliers and decreases in short-stay outlier (SSO) payments due to a change in the SSO payment methodology effective for discharges occurring on or after December 29, 2012.

Expiration of Moratoria Established Under the Medicare Statute: In the Medicare, Medicaid and SCHIP Extension Act of 2007, Congress imposed a three-year moratorium on the effective date of certain LTCH PPS payment policies. At the same time, Congress imposed a three-year moratorium on the development of new LTCHs and LTCH satellites and on increases in the number of LTCH beds in existing LTCHs and LTCH satellite facilities, unless an exception applied. The payment policies subject to the moratorium included:

- Inclusion of the "IPPS comparable per diem amount" option for very short stay cases in the short-stay outlier (SSO) payment formula;
- Implementation of the "25 percent threshold" payment adjustment; and
- Application of a one-time prospective budget neutrality adjustment to the standard Federal rate.

The Affordable Care Act extended the moratoria for two more years, with the moratoria expiring at various times during CY 2012.

With the expiration of the moratoria, CMS will apply the "IPPS-comparable per diem amount" option to payment determinations made under the SSO policy for discharges with a certain length of stay beginning on and after December 29, 2012.

However, the rule includes an extension of the moratorium on the implementation of the "25 percent threshold" payment policy that is generally effective for cost reporting periods beginning on or after October 1, 2012 and before October 1, 2013. For certain LTCHs and LTCH satellites with cost-reporting periods beginning on or after July 1, 2012 and before October 1, 2012, we are also providing a supplemental moratorium effective for discharges occurring on or after October 1, 2012 and through the end of the cost reporting period. This extension is being finalized as proposed in light of CMS's ongoing research which may result in LTCH payment policies that could eliminate the need for the 25 percent rule.

CMS is also applying a one-time prospective adjustment to the standard Federal rate so any significant difference between the data used in the original computations for budget neutrality for FY 2003 and more recent data is not perpetuated in the Prospective Payment System in future years. The rule establishes a permanent 3.75 percent payment reduction to the standard Federal rate to be phased in over three years. The adjustment for FY 2013 is approximately -1.3 percent. The adjustment will not apply to payments for discharges occurring on or before December 28, 2012, consistent with the statute.

Development of the Long-Term Care Hospital-Specific Market Basket: CMS is adopting a stand-alone LTCH-specific market basket based solely on LTCHs' Medicare cost report data that specifically reflect the cost structures of LTCHs. This market basket will replace the Rehabilitation, Psychiatric, and Long-Term Care Hospital (RPL) market basket used under the LTCH PPS prior to FY 2013.

The final IPPS/LTCH PPS rule can be downloaded from the *Federal Register* at:

http://www.ofr.gov/Inspection.aspx?AspxAutoDetectCookieSupport=1.

The Joint Commission

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

May 27, 2010

Jeffery Denney
COO
Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Joint Commission ID #: 148160
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 05/27/2010

Dear Mr. Denney:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning February 19, 2010. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission

June 29, 2009

Salvatore M. Iweimrin
COO
Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Joint Commission ID #: 148160
Program: Laboratory Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 06/29/2009

Dear Mr. Iweimrin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing

This accreditation cycle is effective beginning April 16, 2009. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 25 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

The following laboratory services have been surveyed under Joint Commission standards in accordance with the Clinical Laboratory Improvement Amendments of 1988 :

CLIA# 44D0927731 for the specialties and subspecialties of Routine Chemistry.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160

Evidence of Standards Compliance (60 Day) Submitted: 6/29/2009

Program(s)
Laboratory Accreditation

Executive Summary

Laboratory Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

SUPPLEMENTAL- # 1

The Joint Commission
Summary of Compliance

December 21, 2012
01:16pm

Program	Standard	Level of Compliance
LAB	IM.6.180	Compliant
LAB	QC.1.73	Compliant
LAB	QC.1.75	Compliant
LAB	QC.5.10	Compliant
LAB	QC.6.30	Compliant

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission

April 23, 2009

Salvatore M. Iweimrin
COO
Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Joint Commission ID #: 148160
Program: Laboratory Accreditation
Accreditation Activity: Unannounced Full Event
Accreditation Activity Completed: 04/15/2009

Dear Mr. Iweimrin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission

Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160

Program(s)
Laboratory Accreditation Program

Surveyor(s) and Survey Date(s)
Nancy J. Cacciatore-Huber, MT - (04/15 - 04/15/2009)

Executive Summary

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Findings

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

DIRECT Impact Standards:

Program:	Laboratory Accreditation Program	
Standards:	NPSG.01.01.01	EP3

INDIRECT Impact Standards:

Program:	Laboratory Accreditation Program	
Standards:	IM.6.180	EP1
	QC.1.73	EP3
	QC.1.75	EP3
	QC.5.10	EP4
	QC.6.30	EP5

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

Select Specialty Hospital

FAX COVER SHEET

TO: Stephanie M. **FROM:** Jeff Dem

TO FAX: **FROM FAX:**

DATE: 717-635-3138

CC: **SUBJECT:** Surveys

NUMBER OF PAGES (INCLUDING COVER):

MESSAGE:

Called w/ Question.

DJ

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SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission

Select Specialty Hospital - Memphis

5959 Park Avenue, 12th Floor

Memphis, TN 38119

Organization Identification Number: 148160

Date(s) of Survey: 2/21/2007 - 2/23/2007

PROGRAM(S)

Hospital Accreditation Program

SURVEYOR(S)

Bonnie L. Briggle, MHA, RN

Executive Summary

As a result of the accreditation activity conducted on the above date, your organization must submit Evidence of Standards Compliance (ESC) within 45 days from the day this report is posted to your organization's extranet site. If your organization does not make sufficient progress in the area(s) noted below, your accreditation may be negatively affected.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

717-635-3138

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Assessment and Care/Services

Standard: PC.11.40

Program: HAP

Standard Text: Any use of restraint (to which these standards apply) is initiated pursuant to either an individual order (standard PC.11.50) or an approved protocol (standard PC.11.60), the use of which is authorized by an individual order.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
1. Restraint (except for restraint initiated under a protocol as described in standard PC.11.60) is used upon the order of a licensed independent practitioner.*
* This standard is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care staff (that is, physician assistants and nurse practitioners) to the extent recognized under state law or a state's regulatory mechanism. In the states that allow this delegation, hospitals that permit these individuals to order restraint for medical or surgical reasons are considered to be in compliance with this standard.

Surveyor Findings

EP 1
Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
No physician order was written for restraints for two days as required by hospital policy and regulation.

Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
No physician order was written for restraints for four days as required by hospital policy and regulation.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Quality Improvement Expertise/Activities

Standard: Requirement 2C

Program: HAP

Standard Text: Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

Secondary Priority Focus Area(s): Patient Safety

Element(s) of Performance

Scoring Category : A
4. The organization collects data on the timeliness of reporting critical results/values.

Surveyor Findings

EP 4
Observed in the Data System Tracer at Select Specialty Hospital -Memphis site.
The organization has not been able to collect data on the timeliness of reporting critical results/values due to inconsistent documentation by staff. A process had been recently been implemented to capture the data for analysis.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Life Safety Code

Inpatient Occupancy Existing Healthcare Occupancies; Section V - Exits

Requirement: EC.A.5K.1

Phrase: Existing Health Care Occupancies Exit signs are: readily visible from any direction of access. (EC.A.5K)(EC.A.5K.1)

Surveyor Findings:

At the end of both corridors in the unit, there was only one readily visible exit sign rather than the required two exit signs.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Assessment and Care/Services

Standard: PC.11.100

Program: HAP

Standard Text: Each episode of restraint use is documented in the patient's medical record, consistent with hospital policies and procedures.

Secondary Priority Focus Area(s) Information Management

Element(s) of Performance

Scoring Category : C
2. Documentation includes the following:

Relevant orders for use
Results of patient monitoring
Reassessment
Significant changes in the patient's condition

Surveyor Findings

EP 2
Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
Documentation of the monitoring of the patient in restraints was not complete for four days as required by hospital policy.

Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
In a second patient tracer, documentation of the monitoring of the patient in restraints was not complete for three days as required by hospital policy.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Organizational Structure

Standard: HR.2.10
Program: HAP
Standard Text: The hospital provides initial orientation.

Secondary Priority Focus Area(s) Orientation & Training

Element(s) of Performance

Scoring Category : B
1. The hospital determines what key elements of orientation should occur before staff provide care, treatment, and services.

Surveyor Findings

EP 1
Observed in the Competency Assessment System Tracer at Select Specialty Hospital -Memphis site. The organization has not determined the key elements of orientation that should occur before the contract dialysis and housekeeping staff provide care, treatment and services.

Standard: IM.1.10
Program: HAP
Standard Text: The hospital plans and designs information management processes to meet internal and external information needs.

Secondary Priority Focus Area(s) Information Management

Element(s) of Performance

Scoring Category : B
1. The hospital bases its information management processes on an assessment of internal and external information needs.

The assessment identifies the flow of information throughout a hospital, including information storage and feedback mechanisms.
The assessment identifies the data and information needed: within and among departments, services, or programs; within and among the staff, the administration, and the governance for supporting relationships with outside services and contractors; with licensing, accrediting, and regulatory bodies; with purchasers, payers, and employers; for supporting informational needs between the hospital and the patients; and for participating in research and databases.

Surveyor Findings

EP 1
Observed in the Pharmacy Department at Select Specialty Hospital -Memphis site.
Access to the automated medication dispensing machine at the organization was evaluated by reviewing the most recent three nursing terminations. One of the three nurses continued to have access one week after termination. The Human Resources staff was responsible to notify the Pharmacy Director of terminations. The Human Resources staff member was a new employee and this process had not been addressed in orientation.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Patient Safety

Standard: EC.5.20

Program: HAP

Standard Text: Newly constructed and existing environments are designed and maintained to comply with the Life Safety Code®.

Secondary Priority Focus Area(s) Physical Environment

Element(s) of Performance

Scoring Category : B
1. Each building in which patients are housed or receive care, treatment, and services complies with the LSC, NFPA 101® 2000; OREach building in which patients are housed or receive care, treatment, and services does not comply with the LSC, but the resolution of all deficiencies is evidenced through the following:

An equivalency approved by the Joint Commission Or

Continued progress in completing an acceptable Plan For Improvement (Statement of Conditions™, Part 4)

Surveyor Findings

See Life Safety Code Report

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Rights & Ethics

Standard: RI.2.60

Program: HAP

Standard Text: The hospital addresses the wishes of the patient relating to end of life decisions.

Secondary Priority Focus Area(s) Communication

Element(s) of Performance

Scoring Category : C
21. The policies are consistently implemented.

Surveyor Findings

EP 21
Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
The advance directive section of the initial nursing assessment was not completed as required by the organization's policy and procedure. Documentation did not support any follow up to obtain this information. The patient was admitted to the organization on December 8, 2006.

Observed in the Patient Care Unit at Select Specialty Hospital -Memphis site.
On a second individual tracer, the advance directive section of the initial nursing assessment was not completed as required by the organization's policy and procedure. Documentation did not support any follow up to obtain this information. The patient was admitted to the organization on February 16, 2007.

The Joint Commission

Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160

Evidence of Standards Compliance Received: 4/19/2007

PROGRAM(S)

Hospital Accreditation Program

Executive Summary

As a result of the accreditation activity conducted on the above date, your organization must submit a Measure of Success (MOS) within four (4) months from the day this report is posted to your organization's extranet site. If your organization does not make sufficient progress in the area(s) noted below, your accreditation may be negatively affected.

- The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

Program	Standard	Level of Compliance
HAP	PC.11.40	Compliant
HAP	Requirement 2C	Compliant

The Joint Commission

Select Specialty Hospital - Memphis, Inc.

5959 Park Avenue, 12th Floor

Memphis, TN 38119

Organization Identification Number: 148160

Date(s) of Survey: 4/19/2007 - 4/19/2007

PROGRAM(S)

Laboratory Accreditation Program

SURVEYOR(S)

Kathleen F. Cross, MT

Executive Summary

As a result of the accreditation activity conducted on the above date, your organization must submit Evidence of Standards Compliance (ESC) within 45 days from the day this report is posted to your organization's extranet site. If your organization does not make sufficient progress in the area(s) noted below, your accreditation may be negatively affected.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

The Joint Commission
Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Staffing

Standard: QC.1.40

Program: LAB

Standard Text: The laboratory performs proficiency sample testing in the same manner as patient sample testing.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
2. Proficiency samples are tested along with the laboratory's regular patient testing workload by staff that perform the laboratory's testing.Note: Proficiency testing samples should be rotated among the personnel who perform the test.

Surveyor Findings

EP 2
Observed in Proficiency Testing at Select Specialty Hospital - Memphis, Inc. site for CLIA # 44D0927731.
The blood gas laboratory was not rotating proficiency testing specimens among the testing personnel. All proficiency testing was assayed by one of three employees and the patients' samples could be tested by one of eighteen employees. It is recommended that proficiency testing specimens be rotated among testing personnel so they are truly treated as patient specimens. The results also may be used in assessing personnel competency.

The Joint Commission

Select Specialty Hospital - Memphis, Inc.

5959 Park Avenue, 12th Floor

Memphis, TN 38119

Organization Identification Number: 148160

Evidence of Standards Compliance Received: 6/7/2007

PROGRAM(S)

Laboratory Accreditation Program

Executive Summary

There is no follow-up due to the Joint Commission as a result of the accreditation activity conducted on the above date.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

Program	Standard	Level of Compliance
LAB	QC.1.40	Compliant

The Joint Commission

Select Specialty Hospital - Memphis, Inc.
5959 Park Avenue, 12th Floor
Memphis, TN 38119

Organization Identification Number: 148160
Measure of Success Received: 8/29/2007

PROGRAM(S)
Hospital Accreditation Program

Executive Summary

There is no follow-up due to The Joint Commission as a result of the accreditation activity conducted on the above date.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
781-B AIRWAYS BOULEVARD
JACKSON, TENNESSEE 38301

February 4, 2009

Mr. David Key, Administrator
Select Specialty Hospital
5959 Park Avenue, 12th Floor
Memphis, TN 38119

RE: Licensure Survey

Dear Mr. Key:

On **January 12, 2009** a licensure survey was completed your facility. Your plan of correction for this survey has been received and was found to be acceptable.

Thank you for the consideration shown during this survey.

Sincerely,

Celia Skelley/tw

Celia Skelley, MSN, RN
Public Health Nurse Consultant II

CES/TJW

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

2012 AFFIDAVIT PM 12 21

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 14 day of December (Month), 2012 (Year) a Notary

Public in and for the County/State of Davidson / Tennessee.

NOTARY PUBLIC

My commission expires August 16 (Month/Day), 2016 (Year).

BEVIN M. SHELLENBERGER
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY

My Commission Expires August 6, 2016

SUPPLEMENT #1

FORM APPROVED
December 21, 2012

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
H 675	1200-8-1-.06 (4)(b) Basic Hospital Functions (4) Nursing Services. (b) The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The chief nursing officer must be a licensed registered nurse who is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This Rule is not met as evidenced by: Based on facility policy, medical record review, observation and interview, it was determined the nursing services failed to be organized in a manner to ensure assessments were accurate to trigger appropriate nutritional consults and physician's orders were followed for 3 of 5 (Patients # 2, 4 and 5) patients reviewed. The findings included: 1. Review of facility policy revealed the facility used an initial nutrition screen with a numerical system to ensure patients at moderate or high nutritional risk were referred for a nutrition consult. The assessment documented that a number 3 or higher required a referral to the Registered Dietitian (RD). Medical record review revealed Patient #4 was admitted on 1/8/09 with an infected surgical site and a stage 4 sacral wound. The assessment for this patient documented the patient had a wound and was assessed a 3 or at moderate risk on the initial nursing nutrition screen.	H 675

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

FATE FORM

3138 - 08627

Pg 1 of 9 #1

Tag - # H 675:

Nursing Services
#1) Assessments and Communications with Dietary

1. Upon admission, the admitting/primary nurse will complete assessment. Triggers and prompts on admission assessment may indicate nutritional consult.
2. Process in place on 1/16/09
   a. Admitting/Primary Nurse will log nutritional consult in Dietary Referral Log
   b. Admitting/Primary Nurse will write an order for nutritional consult
   c. Unit secretary will enter order in system and records order number on medical record and log book
   d. RD to view Dietary Referral Log book and computer ordering system daily for any new consults
   e. RD will have admission assessment available for reference via nurse chart.
3. Nursing staff will be required to under go training. Failure to do so will result in suspension pending completion. Training will begin on 1/26/09 by Manager and DCS and will be completed by all nursing staff by 2/28/2009. Ongoing education will be via memos, education board, shift safety briefings and staff meetings.

SUPPLEMENT # 1

FORM APPROVED

December 21, 2012

01:16pm

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TATE FORM 6899 N

Page 1 of 9 #2

3138 - 08628

4. Staff failure to follow process once training complete will be subject to disciplinary action up to termination.
5. Audits will occur weekly times 12 weeks by Nurse Manager, and DCS starting 2/2/09, then ongoing randomly through December 2009 to assure compliance of >90%.
6. Results will be shared with staff at meetings, and posted on staff PI board.
7. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

Tag - # H-675

Nursing Services
#2 Calorie Counts

1. Order will be written by RD or physician for calorie count
2. RD to email DCS and DQM when calorie count order written for "real time" staff compliance monitoring to start 2/3/09.
3. Nursing staff will be required to under go training on calorie count importance and documentation. Failure to do so will result in suspension pending completion. Training will start on 1/26/09 by Nurse Manager and DCS and will be completed by all nursing staff by 2/28/2009. Ongoing education regarding calorie counts will be via memos, education board, shift safety briefings and staff meetings.

SUPPLEMENTAL # 1

December 21, 2012

01:16pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
H 675	Continued From page 1 Medical record review revealed Patient #5 was admitted on 1/6/09 with respiratory distress and with a stage 3 wound. The assessment for this patient documented a 6 on the initial nursing nutrition screen or at high risk. During an interview on 1/12/09, at 2:01 PM, the RD confirmed nutrition services had not received an order for a nutrition consult for either Patient #4 or Patient #5. The RD stated he/she was not aware Patient #4 had a wound when he/she did the nutrition assessment. During an interview on 1/12/09, at 2:44 PM, the Clinical Director confirmed both Patients #4 and 5 should have had an order for a nutrition consult. He/she stated the system nursing services was using to contact for nutrition services was not working. During an interview on 1/12/09, at 2:44 PM, the wound care nurse stated he/she had just completed the wound assessment with pictures and staging. The nurse confirmed this information had not been in the medical record when the nutrition assessment was completed on 1/9/09 by the RD.. 2. Medical record review for Patient #2 documented a physician's order dated 1/7/09 for a 72 hour Calorie Count from 1/8/08 - 1/10/09. Review of the "Calorie Count" documentation for 1/9/09 revealed no information had been documented. During an interview on the meeting on 1/12/09 at 3:05 PM, the RD verified the Calorie Count information was incomplete.	H 675

4. Staff failure to follow process after training complete will be subject to disciplinary action up to termination.
5. RD to email DCS calorie count result on each patient starting 2/3/09.
6. RD will be educated on DCS communication process by DCS/DQM by 2/2/09.
7. Audits will occur weekly times 12 weeks by Nurse Manager and DCS starting 2/2/09, then randomly to assure compliance of >90%.
8. Results will be shared with staff at meetings, and posted on staff PI board.
9. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

Tag - # H-675

Nursing Services Part 2 of #2:
Nutritional Supplements

1. Nursing Staff will be required to under go training on Treatment Administration Record and documentation. Failure to do so will results in suspension pending completion. Training will start on 1/26/09 by Nurse Manager and DCS and will be completed by all nursing staff by 2/28/2009. Ongoing education of dietary supplements will be via memos, education board, shift safety briefings and staff meetings.
2. Staff failure to follow process once training complete will be subject to disciplinary action up to termination.
3. Audits will occur weekly times 12 weeks by Nurse Manager and DCS

SUPPLEMENTAL # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY,
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
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starting 2/2/09, then randomly to assure compliance of >90%
4. Results will be shared with staff at meetings, and posted on staff PI board.
5. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

Tag - # H-733

Food and Dietetic Services:
#1) Wound Assessments:

1. Wound assessments will be done on admission by admitting nurse.
2. RD will review wound assessments on medical record or in nurse chart.
3. For any nutritional consults ordered upon admission, RD will review chart and nurse assessment for determination of patient's nutritional needs.
4. RD will be educated on process by 2/2/09 by DCS or DQM.
5. Failure of RD to follow process once training completed will be reported to host Director of Nutrition Services and will be subject to termination of contracted employment at SSH for this individual.
6. Audits will occur weekly times 12 weeks by Nurse Manager and DCS starting 2/2/09, then randomly to assure compliance of >90%
7. Results will be shared with staff at meetings, and posted on staff PI board.
8. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Reports of audits will be reported through December 2009.

SUPPLEMENTAL # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
H 675	Continued From page 2 Medical record review for Patient #4 revealed an order, dated 1/9/09, for Enure plus with meals . During an interview on 1/12/09, at 1:00 PM, Patient #4 stated he/she had not receive any ensure until lunch on 1/11/09 and then received 2 cans at the same meal. The Patient further stated he/she did not receive any ensure at the dinner meal on 1/11/09 or for breakfast on 1/12/09. On 1/12/09, the Physician again ordered Ensure plus at 1 can TID (three times each day). During an interview on 1/12/09, at 2:30 PM, the Clinical Nurse Manager was unable to find any documentation the Ensure plus had been given prior to 1/11/09.	H 675	Tag – #H-733 Food and Dietetic Services #2) Nutritional Assessments upon admission: 1. Upon admission, the admitting/primary nurse will complete assessment. Triggers and prompts on admission assessment may indicate nutritional consult. 2. Process in place on 1/16/09 a. Admitting/Primary Nurse will log nutritional consult in Dietary Referral Log b. Admitting/Primary Nurse will write an order for nutritional consult c. Unit secretary will enter order in system and records order number on medical record and log book d. RD to view Dietary Referral Log book and computer ordering system daily for any new consults e. RD will have admission assessment available for reference via nurse chart. 3. Nursing staff will be required to under go training. Failure to do so will result in suspension pending completion. Training will start on 1/26/09 by Nurse Manager and DCS and will be completed by all nursing staff by 2/28/2009. Ongoing education will be via memos, education	
H 733	1200-8-1-.06 (9)(c) Basic Hospital Functions (9) Food and Dietetic Services. (c) There must be a qualified dietitian, full time, part-time, or on a consultant basis who is responsible for the development and implementation of a nutrition care process to meet the needs of patients for health maintenance, disease prevention and, when necessary, medical nutrition therapy to treat an illness, injury or condition. Medical nutrition therapy includes assessment of the nutritional status of the patient and treatment through diet therapy, counseling and/or use of specialized nutrition supplements. This Rule is not met as evidenced by: Based on facility policy, medical record review,	H 733		

SUPPLEMENTAL # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN P531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 3811"

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
H 675	Continued From page 2 Medical record review for Patient #4 revealed an order, dated 1/9/09, for Enure plus with meals . During an interview on 1/12/09, at 1:00 PM, Patient #4 stated he/she had not receive any ensure until lunch on 1/11/09 and then received 2 cans at the same meal. The Patient further stated he/she did not receive any ensure at the dinner meal on 1/11/09 or for breakfast on 1/12/09. On 1/12/09, the Physician again ordered Ensure plus at 1 can TID (three times each day). During an interview on 1/12/09, at 2:30 PM, the Clinical Nurse Manager was unable to find any documentation the Ensure plus had been given prior to 1/11/09.	H 675
H 733	1200-8-1-.06 (9)(c) Basic Hospital Functions (9) Food and Dietetic Services. (c) There must be a qualified dietitian, full time, part-time, or on a consultant basis who is responsible for the development and implementation of a nutrition care process to meet the needs of patients for health maintenance, disease prevention and, when necessary, medical nutrition therapy to treat an illness, injury or condition. Medical nutrition therapy includes assessment of the nutritional status of the patient and treatment through diet therapy, counseling and/or use of specialized nutrition supplements. This Rule is not met as evidenced by: Based on facility policy, medical record review,	H 733

board, shift safety briefings and staff meetings.

4. Audits will occur weekly times 12 weeks by Nurse Manager, and DCS starting 2/2/09, then ongoing randomly to assure compliance of >90%.
5. Results will be shared with staff at meetings and posted on staff PI board.
6. Results will also be reported by DCS in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

Tag - #H-733

Food and Dietetic Services
#3 & #4) Wound and Dietary Assessment and Implementation of Orders

1. RD will review wound assessments on medical record or in nurse chart.
2. Wound care RN or Charge Nurse will notify DCS of any wound care admissions for additional follow up on nutritional screening and order implementation.
3. RD will be required to under go training on wound care manual and protocols, and location and accessibility of the wound care manual for reference by 2/2/2009. Failure to complete training will result in termination of contracted employment at SSH for this individual.
4. In-service information and signature sheet will be filed in the in-service manual by 2/9/09 at host facility.

Page 3 of 9 #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 733	Continued From page 3 observation and interview, it was determined the facility RDs failed to follow the facility guidelines for developing a nutrition assessment to meet patient needs to heal pressure ulcers for 2 of 5 (Patient's # 4 and 5) reviewed and to ensure a Physician ordered calorie count was completed for Patient #4. The findings included: 1. Review of the hospital clinical services policy and procedure for patients with wounds, titled "Approach for Wound Care" revealed the following documentation: "Our wound care mission is to ensure prevention of new wounds and appropriate healing of present wound... Team members may include...ET Nurse and Dietician... The process for initiation of wound care included,.:. Nurse (RN) does an admission assessment....photographs wounds... Wound team members do an assessment and make recommendations to the MD (Medical Doctor)." 2. Review of the hospital wound assessment policy and procedure revealed the following documentation: "All patients admitted for wound care will have a comprehensive nutritional assessment done within 72 hours of admission. The goal ... is to ensure that the diet of the patient with a wound contains nutrients adequate to support healing... This normally consists of 30-35 calories/kg (kilogram)/day and 1.25-1.5 grams of protein/kg/day. For severe wounds, this may need to be increased to 40 calories/kg/day and 2.0 grams of protein/kg/day." 3. Patient #4 was admitted on 1/8/09 with	H 733	5. Quarterly random chart reviews will be conducted to ensure patient care is in compliance with protocols by host facility RD Manager. 6. RD Manager quarterly chart review results will be shared with SSH DCS and DQM for compliance. 7. Results will also be reported by DCS/DQM quarterly to MEC and Governing Board. Audit results will be reported through December 2009.	

SUPPLEMENTAL # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 733	Continued From page 4 diagnoses which included an infected right hip with methicillin resistant staph (MRSA) and Sepsis. On 1/9/09, at 7:45 AM, the Physician progress notes documented, "Skin care and decubitus protection and care of ulcer on bottom.... Wound care consult." On 1/9/08 the wound care nurse documented the wound to be a stage 4 sacral wound. The wound was measured to be 3.5 centimeters (cm) in length and 2.5 cm in width. The right hip incision was 4.5 cm with 1.5 cm of tunneling. The initial nutrition assessment done by the facility RD on 1/9/09 at 12:15 PM documented under diagnosis "...hardware removal from hip (bilateral hip surgery)". There was no documentation of a wound. This assessment documented the patient's height at 5 foot 3 inches and a current weight at 103 pounds. By skin assessment was documented, "to be assessed." The estimated calorie requirement was documented as 1100-1300 calories rather than the 1404-1872 calories using facility protocol of 30-40 calories kg for wound healing. Protein was estimated at 55-65 grams of protein rather than 68 grams of protein or higher for a severe wound according to facility protocol. During an interview on 1/12/09, at 2:01 PM, the RD stated he/she was not aware patient #4 had a wound. He/she confirmed the nutrition assessment was completed prior to the nursing wound assessment completed on 1/9/09 also. The RD stated he/she had not received a request for a nutrition consult based on the initial nursing nutrition assessment. 4. Patient #5 was admitted on 1/6/09, with diagnoses which included respiratory failure and	H 733		

Pg 5 of 9

SUPPLEMENTAL - # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

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H 733	Continued From page 5 bowel obstruction. The resident's height was 64 inches and the weight 139 pounds. On 1/7/09, the wound care nurse documented a sacral stage 3 wound 2.5 cm by 1.0 cm in the wound care progress note. On 1/7/09, the nutrition assessment, completed by the RD, documented the wound as stage 2 to the sacral area rather than the stage 3 wound documented by the wound care nurse. The RD assessed the patient required 1.0-1.4 gm/kg of protein rather than 1.25-1.5 gm/kg of protein according to facility protocol. The fluid requirement was estimated to be 1260-1575 milliliters (ml) per kg per day using 20-25 ml of fluid per kg, rather then the 1895 ml or a minimum of 1500ml per day that would have been estimated if the facility protocol of 30-35 ml of fluid per kg per day for wounds had been followed. The RD assessed the current tube feeding product to contain 848 ml of free water but did not assess the total current fluid intake to see if it met the patient's nutritional requirements. During an interview on 1/12/09, at 2:00 PM, the facility RD confirmed the assessment did not meet the facility standard of practice.	H 733		
H 738	1200-8-1-.06 (9)(f) Basic Hospital Functions (9) Food and Dietetic Services. (f) Education programs, including orientation, on-the-job training, inservice education, and continuing education programs shall be offered to dietetic services personnel on a regular basis. Programs shall include instruction in personal hygiene, proper inspection, handling, preparation	H 738		

SUPPLEMENTAL # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN P531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 738	Continued From page 6 and serving of food and equipment. This Rule is not met as evidenced by: Based on review of dietary policies and procedures, observations and interviews, it was determined the facility failed to provide adequate education programs on sanitation. The findings included: 1. Review of facility continuing education programs revealed only one inservice in the last year on sanitation and this was dated 10/08. 2. During an initial tour of the kitchen on 1/12/09, from 9:30 AM to 10:30 AM, a dietary supervisor was observed washing hands with a procedure that re-contaminated the hands. A dietary employee was questioned and was unable to determine the correct amount of sanitizer in the 3 compartment sink. 3. During an interview on 1/12/09, at 10:30 AM, the Dietary Director confirmed that for 2008, all topics which included sanitation, personal hygiene and instruction on handling food and equipment to ensure adequate sanitation were all presented in this 1 inservice.	H 738	**Tag - #H-738** Food and Dietetic Services #1, - #3) In-services, Handwashing and Sanitizer 1) Host staff will be required to under go sanitation in-services and in-services will be documented and signature sheets will be filed in the in-service manual by 2/26/2009. 2) Host staff will be required to under go re-education on proper handwashing technique by 2/26/2009. 3) Nutrition Services employees will be in-serviced on correct sanitizing processes to include PPM by 2/26/09. 4) Host in-service information and signature sheet will be filed in the in-service manual. 5) All ongoing in-services will be documented with signature sheets and filed in in-service manual. 6) Select Specialty Hospital COO and DQM will verify all required in-services at host facility have been	
H 742	1200-8-1-.06 (9)(j) Basic Hospital Functions (9) Food and Dietetic Services. (j) Written policies and procedures shall be followed concerning the scope of food services in accordance with the current edition of the "U.S. Public Health Service Recommended Ordinance and Code Regulating Eating and Drinking	H 742		

Page 7 of 9 #1

SUPPLEMENTAL # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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H 742	1200-8-1-.06 (9)(j) Basic Hospital Functions (9) Food and Dietetic Services. (j) Written policies and procedures shall be followed concerning the scope of food services in accordance with the current edition of the "U.S. Public Health Service Recommended Ordinance and Code Regulating Eating and Drinking	H 742		

Page 7 of 9 #2

SUPPLEMENTAL # 1

PRINTED: 01/14/2009
FORM APPROVED
December 21, 2012

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531147	A. BUILDING _____ B. WING _____	01/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE [illegible] TO THE APPROPRIATE	(X5) COMPLETE DATE
H 742	Continued From page 7	H 742	Tag - #H-742	

Establishments" and the current "U.S. Public Health Service Sanitation Manual" should be used as a guide to food sanitation.

This Rule is not met as evidenced by:
Based on review of dietary policies and procedures, observations and interviews, it was determined the facility failed to follow the facility policy on jewelry use and to follow acceptable standards of practice for hand washing and use of the three compartment sink.

The findings included:

1. Review of facility policies and procedure revealed a policy that stated only wedding bands could be worn by dietary employees and they could not wear earrings or watches.

2. During an initial tour of the kitchen on 1/12/09, at 9:30 AM, a dietary employee was observed wearing earrings which dangled down from the ear.

3. During this tour on 1/12/09, at 9:45 AM, the Surveyor asked the Dietary Director to have someone demonstrate hand washing in the kitchen. A kitchen supervisor washed his/her hands in the hand washing sink, dried the hands and then lifted a cover from a trash can to discard the paper towels thereby recontaminating the hands.

4. During the initial tour of the kitchen, at 10:00 AM, a dietary employee was observed washing pots and pans in the 3 compartment sink. The Surveyor asked the employee to use a test strip to determine if the correct amount of sanitizer

Food and Dietetic Services
1 - # 4) Failure to follow policies

1) Policy discrepancies identified. Policy revisions/updates for type of jewelry allowed to be worn will be completed by 2/23/09 by Director of Nutrition Services.
2) Staff will be required to participate in in-services regarding policy revisions and updates by 2/26/09.
3) Staff will be required to participate in education regarding handwashing technique and 3 compartment sink by 2/26/2009.
4) In-service information and signature sheets will be filed in the in-service manual.
5) Select Specialty Hospital COO and DQM will verify all required in-services at host facility have been held by 2/26/2009 and will audit weekly times 8 weeks starting 3/2/09 and randomly through December 2009 to ensure processes are being followed.
6) Host employees failing to participate in required education and failure to follow processes will be subject to disciplinary action per host facility and suspension of involvement with SSH pending completion.
7) Results will also be reported by DQM/COO in monthly QAPI meetings and quarterly to MEC and Governing Board. Audit results will be reported through December 2009.

SUPPLEMENTAL # 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL MEMPHIS	5959 PARK AVENUE MEMPHIS, TN 38119

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H 742	Continued From page 8 was in the sink. The employee put the test strip into the water. The test strip came out a bright blue/green color. The Surveyor asked the employee if the test strip indicated the correct amount of sanitizer. The employee answered yes but was unable to tell the Surveyor the correct amount of sanitizer. Using the guide, the employee stated the reading was 500 but still stated the amount of sanitizer was correct. During an interview on 1/12/09, at 10:15 AM, the Dietary Manager confirmed the dietary supervisor should not have lifted the trash cover next to the hand washing sink and that the jewelry policy, in the facility policy and procedure manual, was probably old and they allowed stud earrings and watches to be worn in the kitchen.. The Dietary Manager also confirmed the test strip in the 3 compartment sink should have read 200 and there was too much sanitizer in the final rinse. He further stated	H 742		

SUPPLEMENTAL- # 1
December 21, 2012
01:16pm

AFFIDAVIT

2012 DEC 21 PM 12 22

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: SELECT SPECIALTY HOSPITAL - MEMPHIS

I, John Wellborn, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 21st day of Dec., 2012, witness my hand at office in the County of Rutherford, State of Tennessee.

NOTARY PUBLIC

My commission expires August 22, 2016

HF-0043

Revised 7/02

AMANDA L. JONES
STATE OF TENNESSEE NOTARY PUBLIC
RUTHERFORD COUNTY

My Commission Expires Aug. 22, 2016

Copy

Supplemental #2

Select Specialty Hospital - Memphis

CN1212-062

SUPPLEMENTAL- # 2
February 15, 2013
2:43pm

2013 FEB 15 PM 2 43

February 15, 2013

AMISUB (SFH), Inc.
Saint Francis Hospital - Memphis
5959 Park Avenue
Memphis, Tennessee 38119

RE: Proposal for Lease of Space in Saint Francis Hospital, Memphis, Tennessee (the "Building")

Ladies and Gentlemen:

Concurrently with the execution hereof AMISUB (SFH), Inc. (the "Landlord") has executed an Option to Lease ("Option"), subject to the terms of this Letter (herein so called) to enter into negotiations for the restatement, amendment, expansion and extension of that certain lease between Landlord and Select Specialty Hospital – Memphis, Inc. (the "Tenant") dated March 29, 2010 (the "Existing Lease"). A copy of the executed Option is attached hereto as Exhibit A and made a part hereof and the terms of the Option are incorporated herein by the reference. Conflicts or supposed conflicts between the terms of the Option and this Letter will be resolved in favor of this Letter and this Letter will govern and control. Capitalized terms used herein will bear the same meaning as is ascribed to such defined terms in the Option.

The following sets forth our proposal for a New Lease for a proposed long term acute care hospital ("LTACH") to be operated in the Building. This Letter is merely intended to provide a basis upon which the parties may negotiate the New Lease and does not constitute a binding agreement.

Property:	As set forth in the existing Lease
Landlord:	As defined above
Tenant:	As defined above
DBA:	None.
Use:	Tenant shall use the Premises for the purpose of operating therein a long term acute care hospital, for no other purposes except as may be set forth in the Lease, with specific limitations of uses and services which may be provided as set forth in the Lease.
Premises:	The Premises covered by the New Lease will include the premises covered by the Existing Lease and will be expanded to add approximately 21,677 square feet of space ("Additional Premises") located on and covering the entire 11th floor of St. Francis Hospital, effective on be the date to be set forth in the Lease.
Size:	Approximately 43,354 square feet.

Term/ Renewal Option	Five (5) years from the date to be set forth in the New Lease. Tenant will have the right to further extend the Term of the New Lease for an additional five (5) years on terms to be set forth in the New Lease. There will be no right to exercise an option to renew if Tenant is in default or has not continuously operated in the Premises or has entered into an assignment or sublease.
Rent:	As set forth in the Option, to be based upon the fair market value study.
Rent/Option:	To be determined as set forth in the Lease but to be based upon fair market value no less than rent during the primary term.
Taxes, Insurance, Utilities, and CAM expenses:	The Lease will be a gross Lease with Tenant to pay no taxes (except as to its property), Building insurance, utilities or common area maintenance or operating expenses except as may be set forth in the Lease.
Security Deposit:	None.
Financials of Tenant:	Tenant will provide financial statements as may be reasonably requested by Landlord and if not acceptable to Landlord, in Landlord's commercially reasonable discretion, Tenant will provide additional credit enhancement or guaranty as may be required by Landlord to support the expanded commitment as to term and leased space.
Commencement Date:	The earlier to occur of: (i) Tenant's opening of business in the Additional Premises; (ii) 120 days after the date of approval the CON (as defined herein below); provided, however, the absolute outside Commencement Date will be no later than 300 days after the date of full execution of this Letter; .
Delivery of Space/ Landlord Work:	Except for those representations and warranties given in the Existing Lease, Tenant accepts the Premises AS IS. Tenant will do its entire build out and all improvements it deems necessary, at Tenant's sole cost and expense, subject to Landlord approval of plans and specifications (which approval shall not be unreasonably withheld) and Tenant's compliance with Landlord's construction guidelines as will be set forth in the Lease.
T.I. Allowance/ Landlord Work:	None.
Non-competition:	The Lease will contain non-competition covenants running to the benefit of Landlord and Tenant on terms mutually acceptable to Landlord and Tenant. The intent is that no competing healthsystem or hospital, or the employees or affiliates of any such competitor may use or occupy the Premises.

Operations: The Lease will contain substantially similar language to the Existing Lease regarding Tenant's operations.

Assignment: Subject to non-competition covenants, use restrictions, and Tenant continued liability for payment and performance of the Lease, Landlord shall not unreasonably withhold, delay or condition its consent to an assignment or sublease to an affiliate of Tenant. For the purposes of the Lease an "affiliate" of Tenant shall mean (i) any corporation, limited liability company, partnership or other entity under the control of Tenant; or (ii) any corporation, limited liability company, partnership or other entity under the control of Select Medical Corporation. Consent may be withheld if the sublessee or assignee is not an experienced, well recognized and financially stable company. Landlord has elected to negotiate a Lease with Tenant because it is an experienced, well recognized and financially stable company and any assignee or sublessee must be as well.

Signage: Tenant will be permitted to install signs as per the Lease.

Insurance: Tenant will maintain casualty, liability and professional liability insurance as will be required per the Lease.

Leasing Commissions: No leasing commissions are incurred and each party indemnified the other against claims and demands incurred by the other party for commissions arising as a result of the contracts or acts of the indemnifying party.

De-Licensure: Landlord will not be required to de-license any beds as may required by Tenant unless and until Tenant is bound to perform under the terms and provisions of the Lease, subject only to Landlord's performance under the Lease. The Lease will provide that should the Lease ever terminate, Tenant will cooperate with Landlord in its attempts to re-license the de-licensed beds at the hospital and will not contest any attempts by Landlord to re-license or license beds at the hospital. In addition, Tenant will cooperate with Landlord should Landlord elect to reserve or hold as "inactive" the de-licensed beds as may be permitted by applicable authorities. In addition, the Lease will provide that the beds which are de-licensed may not be: (i) transferred from the Premises; or (ii) used or situated in any other facility of Tenant or its affiliates.

Certificate of Need: Tenant has made application for the Certificate of Need ("CON") approval by the Tennessee Health Services and Development Agency ("Agency") for the operation of the LTACH in the Premises. If Landlord and Tenant are not able to reach agreement as to the terms of the Lease, Tenant agrees to withdraw the application for the CON. Landlord is not bound by any terms, provisions, commitments or other assertions or representations made by Tenant in connection with its application for the CON or any matters presented to the Agency in connection therewith. The Landlord is not aware of the contents or assertions of Tenant as are set forth in the application for the CON.

This Letter is intended merely as an expression of intent, and by signing below, each party agrees that (i) the Letter does not create any binding obligation on either party, (ii) either party may terminate Lease negotiations at any time for any reason without liability to the other party, and (iii) any party proceeding on the basis of this Letter (whether with or without the knowledge of the other party) is doing so at its sole risk. The parties shall have no obligation to negotiate in good faith, to use commercial reasonableness or to satisfy any other similar standard in connection with these negotiations. This Letter does not constitute an offer by the Landlord to lease the Premises. Landlord and Tenant agree that, notwithstanding anything to the contract set forth in the Option, Landlord and Tenant have not agreed upon the final terms and provisions of the Lease and those negotiations and potential contracts are subject to subsequent agreements which may be reached in accordance with this Letter. This Letter and the Option are intended to be a summary evidencing the current intentions of the parties with respect to the New Lease, and it is expressly understood and agreed that this Letter and the Option do not constitute and will not give rise to any legally binding obligation on the part of any signatory hereto and that no past or future action, course of conduct, or failure to act relating to the New Lease, or relating to the negotiation of the terms of the New Lease or any other definitive agreement, will give rise to or serve as a basis for any obligation or other liability on the part of either Landlord or Tenant.

I look forward to hearing from you soon.

[SIGNATURE PAGE FOLLOWS IMMEDIATELY HEREAFTER]

SUPPLEMENTAL- # 2
February 15, 2013
2:43pm

Signature page to
Proposal for Lease of Space in Saint Francis Hospital, Memphis, Tennessee

Sincerely,

SELECT SPECIALTY HOSPITAL – MEMPHIS, INC.

David Key,
Vice President

AGREED AND ACCEPTED THIS 15TH DAY OF FEBRUARY, 2013.

LANDLORD:

AMISUB (SFH), INC.
D/B/A SAINT FRANCIS HOSPITAL

By: _____
Name: David L. Archer
Title: President & CEO

ATTACHMENTS: Exhibit A-Option

SUPPLEMENTAL- # 2
February 15, 2013
2:43pm

Signature page to
Proposal for Lease of Space in Saint Francis Hospital, Memphis, Tennessee

Sincerely,

SELECT SPECIALTY HOSPITAL – MEMPHIS, INC.

David Key,
Vice President

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LANDLORD:

AMISUB (SFH), INC.
D/B/A SAINT FRANCIS HOSPITAL

By: _____ 2/15/13
Name: David L. Archer
Title: President & CEO

ATTACHMENTS: Exhibit A-Option

Exhibit "A" Option

Option to Lease

AMISUB (SFH), Inc. (the "Landlord") hereby acknowledges that subject to the further terms and conditions of this Option to Lease ("Option"), Landlord and Select Specialty Hospital – Memphis, Inc. (the "Tenant") have agreed to enter into negotiations for the restatement, amendment, expansion and extension of that certain lease between Landlord and Tenant dated March 29, 2010 (the "Existing Lease"), as follows:

1. New Lease: The Existing Lease will be amended, restated and replaced by a new lease (the "New Lease") covering the premises encompassed by the Existing Lease as well as the Additional Premises described and defined below.

2. Additional Premises: The Premises (herein so called) covered by the New Lease will include the premises covered by the Existing Lease and will be expanded to add approximately 21,677 square feet of space ("Additional Premises") located on and covering the entire 11th floor of St. Francis Hospital, effective on the date to be set forth in the Lease. Landlord will give Tenant access to the Additional Premises to prepare the Additional Premises for Tenant's use at such time as is to be set forth in the Lease.

3. Extended Term/Existing Lease: The Existing Lease may be extended in accordance with the terms of the Existing Lease, so that the Existing Lease will be in effect as to the Premises covered thereby pending the commencement date of the New Lease. Pending the execution of the New Lease and the date that the New Lease is effective, the rights of the parties thereto will be governed by the Existing Lease.

4. Term/New Lease: The Term of the New Lease will be for a period of five (5) years from the date to be set forth in the New Lease. Tenant will have the right to further extend the Term of the New Lease for an additional five (5) years on terms to be set forth in the New Lease.

5. Rent: The rent for the Premises will be fair market value, as determined by the study ("FMV Study") which has been commissioned by Landlord, and is reasonably acceptable to both Landlord and Tenant, to address all regulatory requirements affecting the leasing transaction between the Landlord and Tenant. The FMV Study will call for rent for the Premises as a dollar amount per rentable or usable square foot. Accordingly, any rent amount must be consistent with the FMV Study regardless of the number of beds approved. Even if Tenant receives approval for less than 38 beds on the 11th floor, and thus less than 77 beds on the two floors, rent will be consistent with the FMV Study and not less than that prescribed for the entire Premises per rentable or usable square foot as expressed in the FMV Study. Rent may be quoted in the Lease on a per-bed basis, based upon the number of beds licensed by Tenant. Regardless of the number of beds actually licensed by Tenant, rent will be calculated as determined by FMV Study for the entire Premises. In other words, the rent per bed will increase or decrease depending upon the number of beds approved.

6. De-Licensure: At the time determined by the terms of the New Lease, Landlord will de-license a number of beds equal to the number of beds by which Tenant actually increases the total number of beds in Tenant's hospital, up to a maximum of 38 beds.

This Option and any agreement between Landlord and Tenant is contingent upon the final execution and delivery of the New Lease by and between the parties and the Tenant being granted appropriate Certificate of Need approval by the Tennessee Health Services and Development Agency. Negotiations relative to the New Lease may be terminated, by written notice from one party to the other, at the option of either Landlord or Tenant: (i) at any time that either party determines that agreement has not reached as to final terms of the New Lease; or (ii) the Certificate of Need approval by the Tennessee

Health Services and Development Agency has not been granted as a final, non-appealable approval by September 1, 2013.

[SIGNATURES FOLLOW ON THE NEXT PAGE]

SUPPLEMENTAL- # 2
February 15, 2013
2:43pm

SIGNATURE PAGE TO
OPTION TO LEASE BETWEEN
AMISUB (SFH), INC
AND SELECT SPECIALTY HOSPITAL – MEMPHIS, INC.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto have caused this Option to Lease to be executed by their duly authorized representatives.

LANDLORD	TENANT
AMISUB (SFH), Inc.	SELECT SPECIALTY HOSPITAL – MEMPHIS, INC.
By: _____	By: _____
Name: _____	Name: David Key
Title: _____	Title: Vice President

Dated: _____, 2013

SUPPLEMENTAL- # 2
February 15, 2013
2:43pm

2013 FEB 15 PM 2 43

SIGNATURE PAGE TO
OPTION TO LEASE BETWEEN
AMISUB (SFH), INC
AND SELECT SPECIALTY HOSPITAL – MEMPHIS, INC.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto have caused this Option to Lease to be executed by their duly authorized representatives.

LANDLORD	TENANT
AMISUB (SFH), Inc.	SELECT SPECIALTY HOSPITAL – MEMPHIS, INC.
By: _____	By: _____
Name: David C. Archer	Name: David Key
Title: CEO	Title: Vice President

Dated: 2/15/13, 2013

SUPPLEMENTAL- # 2
February 15, 2013
2:43pm

AFFIDAVIT

2013 FEB 15 PM 2 42

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Select Specialty Hospital -- Memphis

I, Byron R. Trauger, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 15th day of February, 2013, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires March 8, 2016

KATHY M. NICHOLSON
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY, TENN.

HF-0043

Revised 7/02

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2354/Fax: 615-741-9884

February 5, 2013

John Wellborn
4219 Hillsboro Road, Suite 203
Nashville, TN 37215

Re: Certificate of Need Application – CN1212-062
Select Specialty Hosp. Memphis

Dear Mr. Wellborn:

The purpose of this letter is to remind you that your application remains incomplete. By law, if an application is not deemed complete within sixty (60) days after written notification is given to the applicant by agency staff, the application shall be deemed void. This application will be deemed void if it is not complete by February 15, 2013 at 4:30 pm.

The agency received your application on December 14, 2012. Supplemental information was first requested on December 19, 2012. It is imperative that you respond immediately to the December 21, 2012, request for supplemental information. This agency must have time to review your responses to ensure that you have responded fully to all requests for information.

I have enclosed a copy of our last request for supplemental information. Please respond no later than Wednesday, February 13, 2013,by 4:00 p.m.

Sincerely,

Melanie M. Hill
Executive Director

MMH/as

Enclosure

cc: Mark Farber

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
161 Rosa L. Parks Boulevard
3rd Floor
Nashville, TN 37203
615/741-2364

December 21, 2012

John Wellborn
4219 Hillsboro Road, Suite 203
Nashville, Tennessee 37215

RE: Certificate of Need Application CN1212-062
Select Specialty Hospital-Memphis, Inc.

Dear Mr. Wellborn:

This will acknowledge our December 21, 2012 receipt of supplemental information to an application for a Certificate of Need for the addition of twenty-eight (28) long term acute care beds to Select Specialty Hospital-Memphis.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Friday December 28, 2012. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section A, Applicant Profile, Item 6**

   The applicant's anticipation that a fully executed option to lease the additional floor will be submitted under separate cover is noted.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application, the sixtieth (60th) day after written**

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Mark A. Farber
Deputy Director

MAF

Enclosure

HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
MAY 22, 2013
APPLICATION SUMMARY

NAME OF PROJECT:	Select Specialty Hospital-Memphis
PROJECT NUMBER:	CN1212-062
ADDRESS:	5959 Park Avenue Memphis (Shelby County), TN 38119
LEGAL OWNER:	Select Specialty Hospital-Memphis, Inc. 5959 Park Avenue Memphis (Shelby County), TN 38119
OPERATING ENTITY:	N/A
CONTACT PERSON:	John Wellborn (615) 665-2022
DATE FILED:	December 14, 2012
PROJECT COST:	$6,898,392
FINANCING:	Cash Reserves
REASON FOR FILING:	Addition of twenty-eight (28) long term acute care hospital (LTACH) beds to its current LTACH

DESCRIPTION:

Select Specialty Hospital-Memphis is seeking approval for the addition of twenty-eight (28) long-term acute care beds to its current thirty-nine (39) bed LTACH located within St Francis Hospital. The applicant is also in the process of adding ten (10) beds pursuant to TCA 68-11-1607(8)(g) which permits a hospital with fewer than 100 beds to increase its total number of licensed beds by ten beds over any one year period without obtaining a Certificate of Need.. If approved, the final bed count for the facility will be seventy-seven (77) LTACH beds.

SPECIFIC CRITERIA AND STANDARDS REVIEW:

LONG TERM CARE HOSPITAL BEDS

A. Need

1. The need for long term care hospital (LTH) beds shall be determined by applying the guidelines of (0.5) beds per 10,000 population in the service area of the proposal.

   The bed need was calculated by the Tennessee Department of Health, Division for Policy, Planning and Assessment. The 2015 bed need for the applicant's proposed total service area is 122 beds. There are currently 105 licensed beds plus 34 approved but unimplemented beds in the service area for a total of 139 beds. The result is a bed surplus of seventeen (17) beds in the proposed service area.

   It appears that this criterion will not be met.

2. If the project is a bed addition, existing long term care hospital beds must have a minimum average occupancy of 85%.

   There are three long term care hospitals in the proposed service area. The applicant, Select Specialty Hospital–Memphis (39 beds), has experienced occupancy rates of 94.6% in 2009, 89.1% in 2010 and 94.6% in 2011. Methodist Extended Care (36 beds) operated at 89.5%, 86.6%, and 86.3% during the same time period. Baptist Memorial Restorative Care Hospital (30 beds) has operated at 85.2%, 73.2%, and 73.1% during this timeframe. Average areawide occupancy was 90.4% in 2009, declining to 83.7% in 32010, and increasing to 85.6% in 2011.

   It appears that this criterion has been met.

3. The population shall be the current year's population, projected two years forward.

   The Tennessee Department of Health, Division of Policy, Planning and Assessment utilized the applicant's projected total population of the total service area two years forward (2,433,814 residents in CY2015).

It appears that this criterion is met.

4. The primary service area cannot be smaller than the applicant's Community Service Area (CSA). If LTH beds are proposed within an existing hospital, CSAs served by the existing facility can be included along with consideration for populations in adjacent states when the applicant provides documentation (such as admission sources from the Joint Annual Report).

   The applicant states that it has conformed its West Tennessee service area to the boundaries of the West Tennessee CSA.

   It appears that this criterion is met.

5. Long-term care hospitals should have a minimum size of 20 beds.

   The applicant currently is licensed for 39 beds, has an additional 10 beds approved though the exemption for hospitals under 100 beds and is requesting 28 additional beds through this application.

   It appears that this criterion is met.

B. Economic Feasibility

1. The payer costs of a long-term hospital should demonstrate a substantial saving, or the services should provide additional benefit to the patient over the payer cost or over the provision of short-term general acute care alternatives, treating a similar patient mix of acuity.

   The applicant demonstrates that its gross average charge per patient day is significantly less than charges at service area short-term general acute care hospitals. Select had an average gross charge per patient day in 2011 of $4,111. Except for one short-term care hospital, area hospitals have average charges per day in the range of $5,781 to $9,387

   It appears that this criterion is met.

2. The payer costs should be such that the facility will be financially accessible to a wide range of payers as well as to adolescent and adult patients of all ages.

The applicant states that patients aged 18+ are enrolled in Medicare, Commercial, and Medicaid programs. The applicant also notes that it only contracts with one TennCare MCO in the service area, BlueCare. The applicant also stated that admissions are available on a negotiated basis with United Healthcare Community Plan and a contract request was declined by TennCare Select. The applicant also notes that it takes admissions on a negotiated basis from the Arkansas and Mississippi Medicaid programs.

It appears that this criterion has been met.

3. Provisions will be made so that a minimum of 5% of the patient population using long-term acute care beds will be charity or indigent care.

The applicant states that even though its Historical and Projected Data Charts do not reflect charity or indigent care, it does note that it has provided uncompensated care in excess of 5% in each of the three years 2009-2011. .

Since these uncompensated days of care are not directly related to charity or indigent care, it appears that this criterion has not been met.

C. Orderly Development

1. Services offered by the long term care hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional nursing (requiring approximately 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

The applicant states that Select Specialty Hospital-Memphis is located within a 24-hour hospital with a full array of acute care physician specialties available. The applicant states that it provides 12.87 hours per patient day of nursing and therapeutic services.

It appears that this criterion is met.

Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long-term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

Select Specialty Hospital-Memphis is an existing LTACH provider that is already providing these services.

It appears that this criterion is met.

Also, to avoid unnecessary duplication, the project should not include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term care hospitals.

The applicant states that Select Specialty Care-Memphis will never provide services not appropriate for long term acute care hospitals.

It appears that this criterion is met.

2. The applicant should provide assurance that the facility's patient mix will exhibit an annual average aggregate length of stay greater than 25 days as calculated by the Health Care Finance Administration (HCFA), and will seek licensure only as a hospital.

Select Specialty Hospital-Memphis has maintained an average length of stay in the range of 28.7 to 32.2 days over the last four years.

It appears that this criterion is met.

3. The applicant should provide assurance that the projected caseload will require no more than three (3) hours per day of rehabilitation.

The applicant's rehabilitation hours per patient day has ranged between 3.03 and 3.23 over the past two years.

It appears that this criterion is met.

4. Because of the very limited statewide need for long term hospital beds, and their high overall acuity of care, these beds should be allocated only to community service areas and be either inside or in close proximity to tertiary referral hospitals, to enhance physical accessibility to the largest concentration of services, patients, and medical specialists.

   The applicant states that it is located within the West Tennessee CSA and is within five miles of three tertiary hospitals.

   It appears that this criterion is met.

5. In order to insure that the beds and the facility will be used for the purpose certified, any certificate of need for a long term care hospital should he conditioned on the institution being certified by the Health Care Financing Administration as a long term care hospital, and qualifying as PPS-exempt under applicable federal guidelines. If such certification is received prior to the expiration date of the certificate of need, as provided in Tennessee Code Annotated (TCA), Section 68-11-108(c), the certificate of need shall expire, and become null and void.

   The applicant states it is presently certified as a long term acute hospital and qualified as PPS-exempt.

   It appears that this criterion is met.

SUMMARY:

The applicant, Select Specialty Hospital-Memphis, is currently a thirty-nine (39) bed long term acute care hospital (LTACH) located on the 12th floor of St. Francis Hospital at 5959 Park Avenue in Memphis (Shelby County). The applicant is requesting twenty-eight (28) additional LTAC beds to be placed on the 11th floor of St. Francis Hospital. Per TCA 68-11-1607(8)(g) "A hospital with fewer than one hundred (100) beds may increase its total number of licensed beds by ten (10) over any period of one (1) year without obtaining a certificate of need. The hospital shall provide written notice of the proposed increase in beds to the agency on forms provided by the agency, prior to the hospital's request for review to the board of licensing health care facilities". The applicant notified the

Agency of its intent to add ten (10) LTAC beds on October 5, 2012. The applicant expects to also place these 10 beds on the 11th floor resulting in a 38 bed floor. Taking the current 39 licensed beds, adding the additional 10 beds exempted from CON review plus the 28 beds being requested in this application, if approved, the result will be a 77 bed LTACH. The applicant has also stated that St. Francis Hospital will delicense the same number of acute care hospital beds on the 11th floor that Select will re-license as long term acute care.

Note to Agency members: All existing LTACHs (except one) in the service area are under 100 beds, so that all existing LTACHs (except one) are eligible to add 10 licensed beds without a CON if they so choose. (Exception: CN1210-052, Memphis Long Term Care Specialty Hospital has a condition that the addition of any beds requires a CON)

The 11th floor of St. Francis Hospital is currently an acute care nursing unit consisting of 38 private rooms. The floor contains 21,677 square feet. The applicant states that the 11th floor is older space that has not been updated for many years and requires remodeling and renovation. The renovation will consist of updating the wall, floor, and ceiling surfaces, cabinetry, and fixtures, and allowing for plumbing, HVAC, and electrical work. Select Specialty Hospital- Memphis will lease the additional space from St. Francis Hospital.

The applicant states the following reasons for why the project is needed:

- There are only three LTAC facilities in the service area operating at an average occupancy rate of 86.3%
- Select Specialty Hospital-Memphis is operating above 93% occupancy
- This project should not impact existing providers. The Baptist and Methodist LTAC facilities have high utilization. The 24-bed LTACH at the Regional Medical Center of Memphis (The MED), an approved but yet to be implemented project, expects to be fully occupied by The MED acute care patients.

Select Specialty Hospital-Memphis (SSH-M) was originally established through a CON issued to St. Francis Hospital, CN9406-032A, on September 28, 1994 for the establishment of a thirty (30) bed long-term acute care hospital. It appears that Select Specialty acquired the LTACH in 1998. SSH-M is wholly owned by Select Medical Corporation. According to its website Select Medical Corporation (SMC) operates long-term acute care hospitals, medical rehabilitation hospitals or physical therapy outpatient clinics in over 30 states. In addition to Select

Specialty Hospital-Memphis, Select Medical Corporation operates four other LTACHs in Tennessee: Select Specialty Hospital-Nashville (57 beds), Select Specialty Hospital-Knoxville (35 beds), Select Specialty Hospital-North Knoxville (33 beds), and Select Specialty Hospital-TriCities (33 beds).

Long-term acute care hospitals (LTACHs) provide extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that require hospital-level care for relatively extended periods. Typical conditions suitable for admission to LTACH include chronic respiratory disorders and other pulmonary conditions; cardiac, neurological, and renal conditions, infections and severe wounds. A facility must meet Medicare's conditions of participation for acute care hospitals and have an average inpatient length of stay greater than 25 days to qualify as an LTACH for Medicare payment. CMS established regulations to prevent general acute care hospitals from operating LTACHs, but a separate "hospital within a hospital" can qualify, which is the category in which the applicant facility falls.

There are other limitations by CMS regarding source of admissions that LTACHs must follow known as the "25% Rule". In the first supplemental response the applicant points out that this rule limits the percentage of admissions that can be referred from the Host hospitals, which for the applicant is St. Francis Hospital. The applicant states that through November 30, 2013 50% of its Medicare admissions may be referred from St. Francis. After December 1, 2013 that percentage reduces to 25%. The applicant states that historically approximately 20% of its admissions are referred from St. Francis so that Select is in compliance with the referral limitation rules of Medicare. The applicant also discusses being in compliance with referral limitations regarding Baptist and Methodist hospitals.

The applicant also points out in the first supplemental response that CMS (Centers for Medicare and Medicaid Services) established a three year moratorium that began on December 29, 2007 on the designation of new LTACHs or LTACH satellites or an increase of beds in an existing LTACH. On July 23, 2010 the moratorium was extended with an expiration date of December 29, 2012. It is unknown if the moratorium will be re-instituted at a future date but the applicant believes that providers should be ready to occupy needed beds after the moratorium expires. Legislation will need to be introduced and passed in 2013 to re-establish the moratorium. The applicant indicates there is currently an opportunity to add needed LTACH beds during this period.

The applicant states that the SSH-M's primary service area includes two counties in Arkansas (Crittenden and St. Francis), seven counties in Mississippi (Alcorn, DeSoto, Lafayette, Lee, Marshall, Panola, and Tate); and eight counties in Tennessee (Dyer, Fayette, Gibson, Lauderdale, Madison, McNairy, Shelby, and Tipton). The applicant reports that the primary service area counties account for over 85% of admissions and are distributed as displayed in the table below:

Patient Origin	% Admissions	Cumulative %
Shelby, TN	56.1%	56.4%
DeSoto, MS	7.4%	63.8%
Tipton, TN	2.4%	66.2%
Madison, TN	2.1%	68.3%
Fayette, TN	2.0%	70.3%
Marshall, MS	1.8%	72.1%
Dyer, TN	1.8%	73.9%
Tate, MS	1.4%	75.3%
Panola, MS	1.4%	76.7%
Alcorn, MS	1.2%	77.9%
Lee, MS	1.2%	79.1%
Lafayette, MS	1.1%	80.2%
Crittenden, AR	1.1%	81.3%
Gibson, TN	1.1%	82.4%
St. Francis, AR	0.9%	83.3%
Lauderdale, TN	0.9%	84.2%
McNairy, TN	0.9%	85.1%
Secondary Service Area	11.1%	96.2%
Tertiary Service Area	3.8%	100.0%

Source: CN112-062

According to population estimates by the Division of Health Statistics, Tennessee Department of Health (TDOH), the total population of the Tennessee portion of the service area is expected to increase by approximately 1.5% from 1,607,999 residents in CY 2013 to 1,632,644 residents in CY2015. The State of Tennessee population is expected in increase by approximately 1.8% from 6,414,297 in 2013 to 6,530,459 in 2015.

The following table displays demographic statistics for all the counties in the applicant's primary service area based on US Census data and for the Tennessee counties only, TennCare statistics.

Geography	2010 Pop.	2012 Pop.	10 - '12 % Change	Age 65+ % Total	Median HH Income	% Below Poverty Level	TNCare Enrollees	TNCare Enrollees As % of Total Pop.
Tennessee	**6,346,113**	**6,456,113**	**1.7%**	**13.7%**	**43,989**	**16.9%**	**1,205,480**	**18.7%**
Dyer	38,337	38,255	-0.2%	14.8%	38,409	19.2%	9,392	24.6%
Fayette	38,413	38,659	0.6%	15.5%	57,437	11.7%	5,645	14.6%
Gibson	49,683	49,626	-0.1%	16.6%	37,577	17.9%	11,075	22.3%
Lauderdale	27,815	27,718	-0.3%	12.7%	34,078	25.3%	7,216	26.0%
Madison	98,294	98,656	0.4%	13.5%	40,667	19.2%	21,111	21.4%
McNairy	26,075	26,180	0.4%	17.7%	34,953	22.5%	6,950	26.5%
Shelby	927,640	940,764	1.4%	10.4%	46,102	20.1%	230,486	24.5%
Tipton	61,081	61,705	1.0%	11.4%	50,869	15.3%	11,675	18.9%
Arkansas	**2,915,919**	**2,949,131**	**1.1%**	**14.6%**	**40,149**	**18.4%**		
Crittenden	50,902	50,021	-1.7%	11.1%	35,624	27.9%		
St. Francis	28,258	27,858	-1.4%	12.6%	26,260	29.7%		
Mississippi	**2,967,299**	**2,984,926**	**0.6%**	**13.0%**	**38,718**	**21.6%**		
Alcorn	37,057	37,164	0.3%	16.2%	32,221	20.2%		
DeSoto	161,256	166,234	3.1%	10.5%	59,734	9.5%		
Lafayette	47,357	49,495	4.5%	10.6%	41,166	23.8%		
Lee	82,910	85,042	2.6%	13.1%	41,150	18.2%		
Marshall	37,143	36,612	-1.4%	13.3%	33,279	24.2%		
Panola	34,701	34,473	-0.7%	13.0%	34,592	28.1%		
Tate	28,886	28,490	-1.4%	13.1%	41,839	18.1%		

Source: US Census Bureau, TennCare

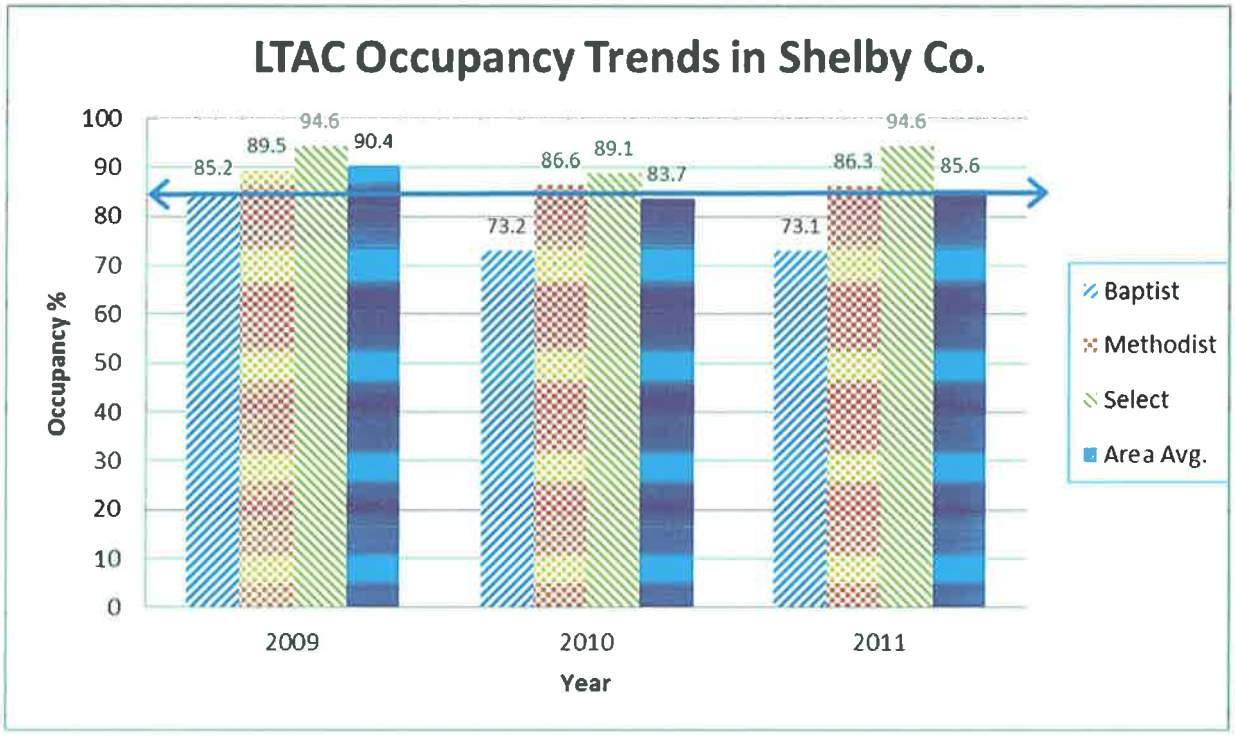
The chart above indicates that all the Tennessee counties in the service area are growing (or declining) at rates less than the Tennessee average, four of the eight Tennessee counties have a higher proportion of Age 65+ population than Tennessee overall, Five of the eight counties have a median household income below the Tennessee median, and six counties have a higher percentage of population below the poverty level than Tennessee overall. The population of the two counties in Arkansas is expected to decline, have a smaller percentage of population Age 65+ than Arkansas overall, have median income below the State median and a greater % of population below the poverty level. Three of the seven Mississippi counties in the service area are expected to have populations that increase more than the state of Mississippi overall. Five of the seven counties have an Age 65+ population equal to or greater than the State

percentage. Three of the counties have a population percentage above the poverty level for the state overall. Seven of the eight Tennessee primary service area counties have a higher percentage of TennCare recipients than the state overall.

The bed need formula from the project specific criteria for long term care hospitals in Tennessee's Health Guidelines for Growth, 2000 Edition, is based upon a ratio of 0.5 beds per 10,000 population (*2 years forward from the current population)* in the service area of the proposal. Using the declared service area population for CY2015 the applicant estimated a need for 122 total LTAC beds. This amount less the number of existing licensed and approved but yet to be implemented LTAC beds (139 *total beds),* accounts for the applicant's estimate that there will be a projected surplus of 17 LTAC beds in the proposed service area. The TDOH project summary reported the same bed need results.

There are three long term care hospitals operating in the proposed service area. The applicant, SSH-M (39 beds plus 10 beds approved but unimplemented per the "Hospital Under 100 bed exemption"), Methodist Extended Care (36 beds), Baptist Memorial Restorative Care Hospital (30 beds). The MED has an outstanding CON for the relocation of approved but unimplemented 24 bed LTACH to its campus (CN1210-052A), resulting in 105 licensed LTACH beds and 34 approved but unimplemented LTACH beds for a total of 139 LTACH beds in the service area. The applicant also notes that there are LTACHs in Nashville, Arkansas, and Mississippi but points out that only three of the twenty-one west Tennessee counties in the service area have a shorter driving time to Nashville than Memphis and all but two of the twenty-one Arkansas and Mississippi counties in the declared project service area are closer to Memphis than to LTACHs in their home states.

The occupancy trends for the existing LTACHs with comparison to the LTACH's criteria and standards' occupancy guideline of 85% are displayed in the following graph.



As the chart above displays, two of the three existing LTACHs have attained the occupancy standard of 85% and the overall annual average occupancy for the three facilities was 85.6% in 2011.

The first year after project completion (2014), the applicant expects the 77 bed LTACH to attain an occupancy rate of 68.8% and increase to 76.6% in 2015. By the fourth year of operation (2017) the applicant expects to attain an occupancy rate of 93.8%. The applicant expects that outreach marketing in Mississippi, Arkansas, and rural west Tennessee will support the projected increase in admissions.

According to the Projected Data Chart for the proposed twenty-eight (28) beds, the applicant expects gross operating revenue of $18,561,633.00 on 4,088 patient days in Year One of the project increasing by approximately 57% to $29,145,658 ($4,670 per patient day) in Year Two. The proposed LTAC bed addition expects to realize favorable operating margins before capital expenditures at an initial level of approximately 4.47% of total net operating revenue in the first year of operations.

For the total 77 bed facility after project completion, the applicant expects gross operating revenue of $87,875,704 on 19,435 patient days in Year 1 and expects to increase 14.6% to $100,672,847 on 21,535 patient days in the second year of operation. The LTACH after project completion expects to realize favorable operating margins before capital expenditures at an initial level of approximately 4.7% of total net operating revenue in the first year of operations.

Historically SSH-M has had a payor mix that included 80% Medicare and 3.3% TennCare/Medicaid. The applicant expects this payor mix to remain the same after project completion.

One of the criteria in the LTACH criteria and standards in the State Health Plan indicates that payer costs in LTACHs should demonstrate a substantial savings compared to the payor costs of a short term general acute care hospital. Utilizing Joint Annual Report data the average gross charge per patient day for the LTACHs in Shelby County ranged from $3,318 to $5,365 averaging $4,228 per day. The average gross charge per patient day for short-term acute care hospitals in Shelby County ranged from $2,626 to $9,387 averaging $7,279 per day.

According to the Historical Data Chart, Select Specialty Hospital-Memphis has been profitable for each of the last three years reporting favorable net operating income (NOI) after capital expenditures of $3,191,077.00 in 2009; $1,882,659.00 in 2010; and $1,089,237.00 in 2011. Average annual NOI was favorable at approximately 5.3% of annual net operating revenue for the year 2011.

The total estimated project cost is $6,898,905. Over 47% of the project cost is facility lease cost ($3,251,550) and another 30% of the cost is construction cost ($2,059,315). Moveable equipment accounts for another 18% of the total project cost ($1,059,315).

The applicant will be renovating the 21,677 square foot 11th floor of St. Francis Hospital for the proposed project. The facility renovation is estimated at $2,059,315 or approximately $95.00 per square foot. The projected cost per square foot is less than the 1st quartile cost of $125.84 for approved hospital renovation projects between 2009 and 2011.

The applicant has provided a letter dated December 20, 2012 from Brasfield and Gorrie, General Contractors that indicates the proposed renovation will meet all

applicable federal, state, and local requirements including the current AIA Guidelines for Design and Construction of Health Care Facilities.

Funding support for the project is available from the corporate parent of SSH-M, Select Medical Corporation, per a letter dated December 14, 2012 from the Executive Vice President & CFO attesting to the availability of $3,647,000.00 from cash reserves and operating income to fund the proposed project.

Select Medical Corporation (Memphis) reported total assets of $17,665,966.85, including $2,601,862.66 in current assets, for the period ending October 31, 2012. Total current liabilities were ($412,519.24). The current liabilities include $1,825,872.01 due from a third party payor. When this amount is excluded from current liabilities the current ratio is lowered to 1.84 to 1. Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

The applicant also included financial statements for Select Medical Corporation. Review of the balance sheet revealed current assets of $483,410,000.00 and current liabilities of $386,062,000.00 for the 12-month fiscal year (FY) period ending December 31, 2011. Review of the Consolidated Statements of Operations revealed net total revenue of $2,804,507,000.00 and net income of $112,762,000.00 after depreciation and income tax expense during the period. Basic and diluted income per common share rose from .61 cents in 2009 to .71 cents in 2011.

The SSH-M's current staffing is 128.2 FTEs and is expected to increase by 55.8 FTEs by the second year of operation. The largest increases are RNs, 39.6 FTEs increasing by 23.3 FTEs to 62.9 FTEs and CNAs, 30.6 FTEs increasing by 15.7 FTEs to 46.3 FTEs

The applicant has submitted the required corporate documentation, real estate option to lease and requisite demographic information for the applicant's proposed service area. HSDA staff has reviewed these documents. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.

Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT

There are no other Letters of Intent, denied or pending applications for this applicant.

Outstanding Certificates of Need

Select Specialty Hospital-Nashville, CN1210-053A, has an outstanding Certificate of Need which will expire on April 1, 2016. It was approved at the February 27, 2013 Agency meeting for the addition of thirteen (13) long term acute care (LTAC) beds to its current forty-seven (47) bed LTAC hospital. The applicant is also in the process of adding ten (10) beds through the exemption for hospitals with less than 100 beds. If approved, the final bed count for the facility will be seventy (70) LTAC beds. The estimated cost of the project is **$3, 4853,811.00.** *Project Status: This project was recently approved.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, pending or denied applications for other health care organizations in the service area proposing this type of service.

Memphis Long Term Care Specialty Hospital, CN1210-052A, has an outstanding Certificate of Need which will expire on February 1, 2016. It was approved at the December 12, 2012 Agency meeting for the relocation of a previously approved but unimplemented CON (CN0908-046AE) for a twenty four (24) bed long-term care acute care hospital (LTACH) from the intersection of Kirby Parkway and Kirby Gate Boulevard, Memphis (Shelby County) to an existing building on the campus of the Regional Medical Center at Memphis (The MED), 877 Jefferson Avenue, Memphis (Shelby County). The LTACH will be placed on the 4th floor of the Turner Tower and will be a separately licensed hospital from The MED. The estimated cost of the project is **$8,208,743.00**. *Project Status: This project was recently approved.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

MAF
05/07/2013

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

2012 DEC 10 08 8:34

The Publication of Intent is to be published in the Memphis Commercial Appeal, which is a newspaper of general circulation in Shelby County, Tennessee, on or before December 10, 2012, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Select Specialty Hospital-Memphis (a long term acute care hospital), owned and managed by Select Specialty Hospital-Memphis, Inc. (a corporation), intends to file an application for a Certificate of Need to add twenty-eight (28) long term acute care beds to its facility, located in leased space at St. Francis Hospital, 5959 Park Avenue, Memphis, TN 38119. The project cost for CON purposes is estimated at $6,900,000. The project contains no major medical equipment and does not add or discontinue any new health service.

Select Specialty Hospital is currently licensed by the Board for Licensing Healthcare Facilities (TN Department of Public Health) for thirty-nine (39) long term acute care beds. Select Specialty has received State approval for licensure of ten (10) additional long term acute care beds without CON review, under a statutory exemption available to hospitals of fewer than 100 beds. Upon its implementation, Select will be licensed for forty-nine (49) long term acute care beds, so that the twenty-eight (28) bed expansion proposed in this Certificate of Need application would increase the Select license to seventy-seven (77) long term acute care beds. St. Francis Hospital, which is leasing these beds to Select, will reduce its current 519-bed general hospital license by 10 beds to reflect the approved 10-bed expansion of Select through the CON exemption process, and will reduce its license by 28 more beds if this CON application is approved. The net effect of these changes will be that the project will not change the service area's total licensed complement of general acute care plus long term acute care hospital beds. The anticipated date of filing the application is on or before December 14, 2012. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 12-9-12 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF HEALTH STATISTICS
OFFICE OF HEALTH STATISTICS
615-741-1954

DATE: February 28, 2013

APPLICANT: Select Specialty Hospital-Memphis
5959 Park Avenue
Memphis, Tennessee 38119

CON: CN#1212-062

COST: $6,898,392

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2000 Edition (2010 Revision)* and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
The applicant, Select Specialty Hospital-Memphis, owned and managed by Select Specialty Hospital-Memphis, Inc. (a corporation), seeks Certificate of Need (CON) approval to add 28 beds to its facility, located at leased space at St. Francis Hospital, 5959 Park Avenue, Memphis (Shelby County), Tennessee. The project contains no major medical equipment and does not add or discontinue any new health service.

Select Specialty Hospital is currently licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities for 39 long term care beds. Select Specialty has received State approval for licensure of 10 additional long term acute care beds without CON review under the statutory exemption available to hospitals of fewer than 100 beds. Upon its implementation, Select Specialty will be licensed for 49 long term care beds, so that the 28 bed expansion proposed in the CON would increase the Select Specialty's license to 77 long term acute care beds. St. Francis Hospital, which is leasing these beds to Select Specialty, will reduce its current 519-bed general hospital license by 10 beds to reflect the approved 10-bed expansion of Select Specialty through the CON exemption process, and will reduce its license by 28 more beds if this CON application is approved. The net effect of these changes will be that the project will not change the service area's total licensed complement of general acute care beds, plus long term acute care hospital beds.

The project will involve the renovation of 21,677 square feet of space at a cost of $2,059,315 or $95 per square foot. The 2009-2011 acute care construction projects approved by HSDA. The project's $95 per square foot cost is below the first quartile average for renovation of $125 per square foot.

Select Specialty Hospital-Nashville, Inc. is 100% owned by Select Medical Corporation of Mechanicsburg, Pennsylvania, which owns five Tennessee facilities.

The total projected cost of the project is $6,898,392 and will be financed/funded by the hospital from cash reserves currently available. The hospital's intent to finance is provided in Attachment C, Economic Feasibility-Item 2.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition (2010 Revision).*

NEED:

The following charts illustrate the applicant's Tennessee primary and secondary service area.

Primary Service Area Total Population Projections for 2013 and 2015

County	2013 Population	2015 Population	% Increase or (Decrease)
Dyer	39,238	39,682	1.0%
Fayette	39,818	41,105	3.2%
Gibson	49,303	49,637	0.7%
Lauderdale	28,641	29,220	2.0%
Madison	101,634	103,431	1.8%
McNairy	26,476	26,722	0.9%
Shelby	956,126	970,591	0.6%
Tipton	63,857	65,839	3.1%
Total	**1,305,093**	**1,326,227**	**1.6%**

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics

Secondary Service Area Total Population Projections for 2013 and 2015

County	2013 Population	2017 Population	% Increase or (Decrease)
Benton	16,779	16,903	0.7%
Carroll	29,970	30,243	0.9%
Chester	17,031	17,322	1.7%
Crockett	15,336	15,644	1.8%
Decatur	11,509	11,546	0.3%
Hardeman	30,299	30,941	2.1%
Hardin	26,955	27,465	1.9%
Haywood	19,786	19,949	0.8%
Henderson	28,170	28,626	1.6%
Henry	32,834	33,179	1.0%
Lake	7,393	7,386	-0.1%
Obion	32,839	33,061	0.7%
Weakley	33,970	34,152	0.5%
Total	**302,906**	**306,417**	**1.2%**

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics.

Shelby County Long Term Care Hospital Utilization, 2011

Facility	Licensed Beds	Occupancy
Baptist Memorial Restorative Care	30	75.5%
Methodist Extended Care	36	86.3%
Select Specialty Hospital-Memphis	39	94.6%
Total	**105**	**Average: 86.3%**

Source: *Joint Annual Report of Hospitals, 2011,* Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics.

In addition to the above beds, The Med in Memphis has been approved for 24 beds and the applicant added 10 beds per the 10 bed pool. The total active and approved beds in the service area are 139.

Currently, there are only three long term-care hospitals in the entire primary and secondary service area, and all of those are located in Memphis. The above chart provides the 2011 bed total and occupancy rates for those facilities. At these high occupancies, it appears more are long term care hospital beds are appropriate. Currently, there are 129 long term care hospital beds either in service or approved for the service area. Although the bed need formula indicates there is not a need for more beds, the Guidelines

for Growth allows the HSDA Board members to consider bed additions once area wide long term care hospital occupancy reaches 85%, which has been exceeded for at least three years.

The CON statute allows small hospitals with less than 100 beds to add 10 beds every year without CON approval. Without a CON, the 38 total beds Select can lease from St. Francis could be added in stages each year until all 38 beds are licensed in early CY2016, three years from the present. However, staging beds licensure would require staged renovation around patients being hospitalized on that floor. The applicant's alternative being requested in this application will let Select lease and license the remaining 28 beds from St. Francis without delay, making it feasible to invest in renovating the entire floor at the same time. This is a logical alternative to adding 10 beds each year and not subjecting current and future patients to the inconvenience of renovation.

For the 77 bed project in this application, the applicant projects 677 patient days in year one with 19,345 patient days and year two admissions of 753 with 21,535 patient days.

TENNCARE/MEDICARE ACCESS:
The applicant participates in the Medicare and Medicaid programs and contracts with BlueCare and TennCare Select MCOs, and admits United Healthcare Community Plan admissions on a negotiated basis.

The facility had a Q1 thru Q3 2012 payor mix of 80.02% Medicare, 3.3% Medicaid, 15.48% commercial and Workmen's Comp, and 1.3% other. The applicant's projections assume that the Medicare and Medicaid payor mix will remain the same through CY2015.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics have reviewed the Project Costs Chart, the Historical Data Chart (when applicable) and the Projected Data Chart and has determined they are mathematically accurate and the projections based upon the applicant's anticipated level of utilization are mathematically accurate. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Cost Chart is located on page 45 of the CON application. The estimated project cost is $6,898,392.

Historical Data Chart: The Historical Data Chart is located on page 49 of the CON application. The facility reported 13,473 patient days and 94.6% occupancy, 12,680 patient days and 89.1% occupancy, and 13,469 patient days and 94.6% occupancy each year respectively. The net operating income reported was $3,191,077, $1,882,659, and $1,089,237 each year, respectively.

Projected Data Chart: The Projected Data Chart is located on page 50 of the CON application. The applicant projects 677 patient days in year one with 19,345 patient days. In year two admissions are expected to be 753 with 21,535 patient days, with a net operating income of $1,392,585 and $1,672,004 each year, respectively.

The applicant's projected average gross charge for CY2014 is $4,543 per day, with an average deduction of $3,012, resulting in an average net charge of $1,531 per day. The projected CY2015 gross charge per day is $4,675, with an average deduction of $3,127, resulting in an average charge per day of $1,548 per day. The applicant compares their average gross charge with those of other providers on page 56 of the CON application.

The alternative of not adding beds at this location was rejected by the applicant for the following reasons: 1) the hospital has coped with a high occupancy of 93% and routine deferrals of qualified admissions for several years due to lack of bed space. 2) the availability of beds for conversion located immediately below the existing floor offers a feasible opportunity to expand efficiently without relocation or new construction, at a low capital cost. 3) Visits to hospitals and physicians in outlying counties of the service area have convinced hospital management that significant latent additional need for long term

acute inpatient care exists there, which Select can meet if it undertakes the approved and proposed bed expansions.

The applicant reports The Med's representatives have told HSDA that the MED's own demand for these beds from patients using long term care beds in the community, is more than enough to fill completely the 24 beds being acquired and moved to the MED campus.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:

Select Specialty Hospital is located within the tertiary St. Francis Hospital. St. Francis is its "host. Select contracts with the host hospital and the host's vendors to deliver the ancillary and support services needed by its patients.

Select Specialty Hospital does not project that this project will have any significant or persistent impact on the other existing long term acute care providers in the service area. The MED, Baptist, and Methodist believe that their occupancies will not be reduced significantly by Select's provision of beds to meet Select's own admission needs.

Select believes any impact this project will have on other providers will be small and of short duration. Select anticipates drawing most of its new patients from large hospital providers outside of Memphis. Currently, eleven hospitals refer patients to Select.

The current and proposed staffing for this project is provided by the applicant of page 63 of the CON application.

The applicant is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities; certified by Medicare and Medicaid and accredited by The Joint Commission.

The applicant's most recent Joint Commission Survey is provided in Supplemental 1.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition* (2010 Revision).

LONG TERM CARE HOSPITAL BEDS

A. Need

1. The need for long term care hospital (LTH) beds shall be determined by applying the guidelines of (0.5) beds per 10,000 population in the service area of the proposal.

The calculated bed need for the service area using the above formula shows a need 122 beds.

Shelby County Long Term Care Hospital Utilization, 2011

Facility	*Licensed Beds*	*Occupancy*
Baptist Memorial Restorative Care	*30*	*75.5%*
Methodist Extended Care	*36*	*86.3%*
Select Specialty Hospital-Memphis	*39*	*94.6%*
Total	***105***	***Average: 86.3%***

*Source: Joint Annual Report of Hospitals, 2011,*Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics

In addition to the above beds, The Med in Memphis has been approved for 24 beds and the applicant added 10 beds per the 10 bed rule. The total active and approved beds in the service area are 139.

2. If the project is a bed addition, existing long term care hospital beds must have a minimum average occupancy of 85%.

The three long term care acute hospitals in the service area reported a combined occupancy 86.3% in the most recent reporting year; two of the three exceeded 86% and Select had 94.6% occupancy.

3. The population shall be the current year's population, projected two years forward.

The Division of Policy, Planning, and Assessment utilized the current population projected two years forward to calculate the bed need.

4. The primary service area cannot be smaller than the applicant's Community Service Area (CSA). If LTH beds are proposed within an existing hospital, CSAs served by the existing facility can be included along with consideration for populations in adjacent states when the applicant provides documentation (such as admission sources from the Joint Annual Report).

The applicant conformed its West Tennessee service area to the boundaries of the West Tennessee CSA. Almost all of the counties in the applicant's admission based service area are within the West Tennessee CSA. Counties in Mississippi and Arkansas are included based on the actual admissions from those out-of-State counties.

B. Economic Feasibility

1. The payer costs of a long-term hospital should demonstrate a substantial saving, or the services should provide additional benefit to the patient over the payer cost or over the provision of short-term general acute care alternatives, treating a similar patient mix of acuity.

Table Nine on page 22 of the application compares the applicant's current charges per patient to those of other long term acute care hospitals in Shelby County.

2. The payer costs should be such that the facility will be financially accessible to a wide range of payers as well as to adolescent and adult patients of all ages.

Adult patients enrolled in commercial, Medicaid, and Medicare insurance programs are served by the facility. The applicant provides a chart on page 23 of the CON application illustrating the payor mix of the facility for CY2011 and YTD 2012.

3. Provisions will be made so that a minimum of 5% of the patient population using long-term acute care beds will be charity or indigent care.

The applicant's Historic and Projected Data Charts for this project do not reflect charity care to uninsured or under insured persons per se, but the applicant states it does provide a substantial amount of uncompensated care.

Select Medical Corporation (the parent company) and its hospitals use the term "FLO' days (meaning "fixed cost outliers") to record uncompensated days of care.

The applicant provides a chart on page 24 of the application illustrating the uncompensated care days using the FLO process.

C. Orderly Development

1. Services offered by the long term care hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional

nursing (requiring approximately 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyper alimentation, care of ventilator dependent patients, long term antibiotic therapy,
long term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

Also, to avoid unnecessary duplication, the project should not include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term care hospitals.

(a) Select Specialty complies with this criterion. The long term acute care beds are located within a 24-hour hospital with a full array of acute care physician specialties available and on-call.

(b) Select Specialty provides care for types of patients listed in this criterion.

(c) Select Specialty Hospital-Memphis has never, and will never, provide the referenced services or any other services not appropriate for long term acute care hospitals.

2. The applicant should provide assurance that the facility's patient mix will exhibit an annual average aggregate length of stay greater than 25 days as calculated by the Health Care Finance Administration (HCFA), and will seek licensure only as a hospital.

Table twelve on page 26 of the CON application provides documentation that this hospital's ALOS exceeds 25 days of care, and is projected to continue to exceed 25 days.

3. The applicant should provide assurance that the projected caseload will require no more than three (3) hours per day of rehabilitation.

Table thirteen on page 26 of the CON application provides nursing and rehabilitation hours per patient in CY2011 and CY 2012 YTD.

4. Because of the very limited statewide need for long term hospital beds, and their high overall acuity of care, these beds should be allocated only to community service areas and be either inside or in close proximity to tertiary referral hospitals, to enhance physical accessibility to the largest concentration of services, patients, and medical specialists.

The applicant is located within a CSA, is within a tertiary care referral hospital, and is within five miles of two other tertiary referral hospitals in Memphis.

5. In order to insure that the beds and the facility will be used for the purpose certified, any certificate of need for a long term care hospital should be conditioned on the institution being certified by the Health Care Financing Administration as a long term care hospital, and qualifying as PPS-exempt under applicable federal guidelines. If such certification is received prior to the expiration date of the certificate of need, as provided in Tennessee Code Annotated (TCA), Section 68-11-108(c), the certificate of need shall expire, and become null and void.

This condition is already met. The applicant is presently certified as a long term hospital and qualified as PPS-exempt.